Operational Review

Hamilton-Wentworth
Community Care Access Centre
Centre d'accès aux soins communautaires

April 2, 2001

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OPERATIONAL REVIEW OF THE HAMILTON-WENTWORTH COMMUNITY CARE ACCESS CENTRE (HWCCAC)

EXECUTIVE SUMMARY

The Hamilton-Wentworth Community Care Access Centre (HWCCAC) is an organization experiencing considerable difficulty in its attempt to fulfill its mandate. Although it inherited weaknesses from the agency it succeeded, the effectiveness of the organization has deteriorated in its three years of existence. The financial position has changed from a balanced budget to a rapidly growing deficit. There are departures from provincial policy and regulations in providing client services, and staff morale is deteriorating.

The board and management have worked hard to provide services to their community, and managed to maintain services through two strikes. However, the review team found many departures from operational expectations of all CCACs throughout Ontario.

The enormous amount of change in senior management has had a detrimental effect; and most of the changes have been caused by, or supported by, the CCAC's board. The current senior management team members, while enthusiastic, are largely inexperienced in the CCAC business – a very challenging, complex and specialized operation. The frequent personnel changes have prolonged the period of "settling in" that can be expected in new organizations. After three years, this agency would be expected by now to be operating effectively and efficiently. This was not evidenced by the findings of the review.

Major Findings and Observations

1. The organization has a number of strengths it can build on:

    - There is still an abundance of experience and understanding of the business among front line and middle management staff.
    - The financial services area seems to be gaining strength.
    - There has been some good work done in developing policy manuals.
    - There is recognition by management that the principal management information system is inadequate. Efforts are being made to acquire a better system.
    - The Request for Proposals (RFP) process for establishing contracts with agencies to provide client services seems to run effectively and efficiently.

2. The board, as investigated and stated in this report, is generally naïve about its public accountability, arrogant in its *modus* operandi, largely oblivious to the need for

proactive communications with its primary stakeholders, and lax in not acting more quickly on a worsening fiscal crisis when it confesses to have known about its own service delivery deficiencies.

3. The board provided inadequate strategic direction and leadership, was ineffective in communicating with stakeholders including its staff, failed to ensure accountability and transparency in its operation, and by trying to manage the day-to-day operations, created a climate that made it difficult for CEOs to exercise their appropriate role.

4. A CCAC is a big business but the HWCCAC has a critical shortage of people with business skills or experience among both the board and senior management. As a result, there is a need for renewal of the board and a need to assess the skill mix of the senior management team.

5. At the senior management level, there was little understanding of the factors contributing to the deficit. The review identified that the major contributor to the growing deficit over the past year was the sharp increase in the total volume of homemaking services provided. This was created by a failure to consistently apply eligibility criteria for homemaking services, and by failing to carefully monitor service needs to ensure clients remained eligible, received only necessary services, and were discharged as soon as possible; however, from the CEO's perspective, as indicated to the reviewers, there was no problem with homemaking utilization.

6. There is poor understanding of how to appropriately correct the situation of "snowballing" expenditures. The CEO advised that nothing could be done to address the deficit until the organizational redesign had been implemented. In fact, the review team found that elements of the redesign have weakened the ability to manage service levels.

7. There is no effective monitoring or management of service utilization and caseload, the greatest drivers of CCAC costs. As a result, existing resources are not used efficiently leaving reduced resources available to provide the services intended under the CCAC mandate. There is little understanding of how monitoring could be improved, other than to obtain a new information system.

8. The system for assessing which clients should be the highest priority for services is inadequate.

9. The mandate of CCACs is to provide access to long-term care services through case management and placement coordination processes. These processes were found to be weak. The case managers/placement coordinators seemed sufficiently capable, but the weakness of the processes was found to be mainly due to the direction the staff were receiving from senior management.

10. The case management function of the CCAC was further eroded through the CCAC's recent organizational redesign and re-configuration of case management services – noted in the "System Redesign" section of the report. The redesign, although attempting to better distribute the workload, weakens the role of case managers, for

example, by eliminating the need for initial case manager assessment for routine and single service referrals from hospitals.

11. It appeared that the CCAC board and senior management did not recognize the importance of strong case management and placement co-ordination roles. This is a core business of a CCAC to ensure effective client service delivery and resource management. Together, these roles ensure that the right clients are provided with the right services at the right time, that services are adjusted as needs change, that clients are discharged as soon as a CCAC service is no longer needed and that alternative services are found for clients no longer eligible, if necessary.

12. The increase in homemaking volumes was influenced by the CCAC's inconsistent application of *Regulation 386/99* under the *Long Term Care Act*, which confirms the requirement that clients eligible for homemaking services must need help with personal support (bathing, etc.). The regulation also outlines certain conditions under which the service may be provided for people with acquired brain injury or cognitive impairment. This regulation was designed to deal with high-needs clients who had a need for personal support, but who received the support through the assistance of others. In these situations, the regulation would allow for homemaking services. HWCCAC documents and interviews indicated that, as early as January 1999, the CCAC was interpreting a draft of the regulation to mean that homemaking could be provided to clients even if they did not require "personal support." This means that services were being provided to people who were not eligible.

13. Another area of non-compliance with the same regulation relates to the homemaking service maximums provided to high-needs clients. *Regulation 386/99* states that eligible people may receive up to 80 hours of homemaking in the first month of service, and up to 60 hours a month for consecutive months. It was found that in many cases, a maximum of 40 hours was applied. Many case managers were not aware that 80 hours the first month was possible; and the 60 hour maximum required internal approvals that case managers often found too difficult to pursue or obtain. The effect of this non-compliance would likely be that some eligible people with higher needs were not admitted. One objective of CCAC services is to provide an alternative to care in an institutional environment. When people with higher needs are not admitted, this objective is poorly met: some people would unnecessarily be in institutional beds, families would receive less support, and clients at home could potentially be at risk. In addition, one objective of the LTC Act, to provide equitable access to services across the province, would be poorly achieved in the region.

14. The authorization of therapy services was inadequate with open-ended service plans being given to the outside service providers. This contributed to the steep increase in therapy services and costs.

15. Compliance with other policy on client eligibility was impossible to assess due to poor documentation on client records.

16. There is a quality control issue in the area of the implementation of client service plans. It was found that there was a high incidence of services ordered but not provided *(Long-Term Care Act*, Section 23), raising concerns about client risk and readmission to hospital.

17. There has been insufficient attention paid to the implementation of new undertakings at all levels of the organization.

18. Front line staff and managers at all levels had little clear direction. Expectations are not well spelled out, neither in job descriptions nor through informal means. Staff cannot perform well nor enjoy job satisfaction if there is lack of clarity of their role.

19. There are many staff who have not had recent performance appraisals.

20. At the point of the review, little had been done to improve the deteriorating staff morale, in spite of the February 2000 staff survey indicating serious morale issues.

Based upon the findings and recommendations of the review of the agency's governance and operations, the ministry should quickly take appropriate steps to ensure:

- outright board renewal,
- an objective assessment of the skill mix of the senior management team,
- effective case management processes.

In accordance with the review's recommendations, the strengthened HWCCAC should implement a plan to manage service volumes, based upon:

- clear and reasonable prioritisation of services,
- careful eligibility assessments,
- timely reassessments,
- constant caseload and service monitoring,
- prompt discharges.

The senior management team will need extensive help and training to understand how to manage the business of a CCAC. This can be best accomplished by using someone from outside the organization with expertise in managing the home care business. There may be experienced people at the middle management level within the HWCCAC who can assist, but outside expertise at the senior management level will be essential to fill the experience gap and further assess the adequacy of the CCAC senior management team's skill mix.

The effective implementation of the recommendations of this review should result in an improved organization with enhanced ability to meet the community's need for services and the taxpayers' need for accountability.

INTRODUCTION

In January of 2001, the Ministry of Health and Long-Term Care initiated a comprehensive operational review of the Hamilton-Wentworth Community Care Access Centre (HWCCAC). The review team was asked to assess the HWCCAC's capacity to fulfil its mandate to manage this large and important component of the area's health care system, and to identify factors contributing to its growing deficit. The work of the review team was divided into two parts: Operations and Governance. The Operations section was reviewed in three categories: Finance, Program, and Management.

For the fiscal year ended March 31, 2000, the HWCCAC had a deficit of $615,442. During fiscal year 2000/01, the agency's projected deficit increased rapidly. At the start of this review, expenses exceeded revenues by approximately $500,000 per month. In September 2000, the HWCCAC was advised of a base funding increase of approximately $3.5 M bringing its total annual funding to $53.2 M. After receiving this funding increase, the HWCCAC continued to project a remaining deficit of $5.4 M. The net impact of the HWCCAC's base adjustment and the remaining deficit of $5.4 M would be equivalent to a 19% increase in the HWCCAC's 2000/01 budget. The dramatic increase in deficit, coupled with the lack of an effective plan to manage service volumes, contributed to the need for an operational review.

The HWCCAC was faced with a service provider problem this fiscal year because of a strike by one of its contracted service delivery agencies - the Victorian Order of Nurses (VON) Hamilton. This was followed by a 10-week strike by the HWCCAC's own workers. These and other HWCCAC issues were raised by the local media.

New funding for CCACs is based on a provincial equity funding formula, which is population based, and reflects the additional case management needs of regional referral centres such as Hamilton. The funding approach was introduced in 1995/96 to promote equitable funding across the province. The formula is based on the age and sex of the population and provincial home care utilization by age cohort. It has been reviewed and adjusted in collaboration with the provincial association of CCACs, and is currently undergoing a further collaborative review to see if additional factors can and should be included. The HWCCAC has received a total of $8,079,971 in new funding since its inception on October 1, 1997. This represents a 17.8% increase in funding.

Public accountability requires transfer payment agencies to operate within budget and to use public funds as intended under their assigned mandates. The management of costs for home care services - the major component of CCAC costs - is particularly challenging. Unlike hospitals and long-term care facilities, that have more control over costs through a fixed number of approved beds, the delivery of services to people at home has no such built in control. Hundreds of people are admitted every day and unless a sizeable number of people are also discharged, a snowball effect increases costs rapidly. Costs eventually will surpass the ability of taxpayers to fund them, and the program would become unsustainable. These services therefore require close, constant monitoring and timely corrective action if expenditures threaten to surpass funding.

Service management is achieved through the following:

- careful focus on the program mandate and priorities,
- strict application of provincial policy for eligibility and services,
- adjustment of clients' services quickly when their needs change,
- a focus on assisting clients to maintain their maximum independence,
- discharge of clients from the service as soon as their service goals are met.

Because of the huge volume of clients and services, cost overruns can be reversed quickly without detrimental effects on clients if they are discovered and corrected early. Accordingly, the review assessed the HWCCAC's service management in addition to its resource management.

BACKGROUND

The mandate of Ontario's CCACs is to provide simplified access to a broad range of long-term care community-based services. Under this mandate, there are several broad functions: information and referral, case management (which includes assessment, eligibility determination, service planning, etc.), admission to long-term care facilities, and contract management.

The HWCCAC is responsible for these services for the Hamilton-Wentworth region.

CCACs purchase a range of in-home services and supplies through contracts with outside agencies. Each CCAC is accountable for managing the resources provided by the ministry for this purpose. In the Hamilton area, the HWCCAC has been responsible for these services since October 1st, 1997, when the governance and management of home care and placement coordination was transferred to the HWCCAC from the local branch of the Victorian Order of Nurses (which remains a provider of nursing services to the HWCCAC). There was no deficit at the time of the transfer.

Over its first three years of operation, the HWCCAC has had four CEOs (one on an "acting" basis), five Directors of Client Services, and two Directors of Finance. The current senior management team members were newly appointed to their positions at various times within the year prior to the review. All but one of these managers are quite new to the CCAC business, and the one with CCAC experience is assigned to a role that focuses on activities external to the HWCCAC's principal operations.

There was a ten-week strike by the HWCCAC's unionized (case management and clerical) staff in the fall of 2000. During the strike, managers were fully occupied maintaining services for clients and were not able to pursue their normal activities. This fact was taken into account in assessing the agency's performance.

GENERAL METHODOLOGY

The agency's performance in fulfilling its mandate was reviewed within the framework of accountability guidelines established by Government of Ontario's Management Board. These include:

- setting expectations,
- contracting,
- monitoring,
- reporting,
- corrective action.

Setting Expectations

For CCACs, expectations have been set by the ministry through legislation, regulations and policy, and in legal agreements, budgets, notifications of new funding and other directives. CCACs also set internal expectations through job descriptions, internal policy manuals, and staff directives, etc.

The following are some of the standards against which the HWCCAC's performance was measured:

The primary legislation governing CCACs is the *Long-Term Care Act, 1994*. In addition, *An Act To Amend Certain Acts Concerning Long-Term Care, 1993,* has relevance to the CCAC's placement services.

The purposes of the *Long-Term Care (LTC) Act* are to:

- ensure a wide range of community services exist as alternatives to institutional care,
- provide support and relief to relatives and others who provide care for a person at home,
- promote equitable access to community services through the application of consistent eligibility criteria and uniform rules and procedures,
- promote the effective and efficient management of human, financial and other resources involved in the delivery of community services,
- promote co-operation and co-ordination between providers of community services and providers of other health and social services.

The *Long-Term Care Act* includes a process for client complaints and appeals, and a Client Bill of Rights. It addresses funding, approvals and defines the services covered. Services provided by CCACs include: homemaking services, personal support services, and a range of professional services including nursing, physiotherapy, occupational therapy, speech and language pathology, social work and others.

Several regulations have been passed:

- *Regulation 386/99* - about eligibility requirements and service maximums, in July 1999,
- *Regulation 494/00* -about the provision of school health support services in private and home schools in August 2000,
- *Regulation 677/00* - about the provision of personal support services in private and home schools in December 2000.

The provincial *Home Care Program Policy and Procedures Manual, 1984* provides the current policy reference. A combined ministry and CCAC group is currently developing a CCAC program manual. In addition to the 1984 manual, many policy directives have been distributed to former home care agencies and the CCACs.

A Management Support Initiative resulted in the creation of two documents providing policy direction to promote a more standardized approach to CCAC service delivery across the province. Policies addressed issues such as the provision of incontinence supplies and equipment rental.

Provincial policy for placement services is outlined in the ministry's *Placement Coordination Services Manual.*

In addition, the ministry has produced and maintains the *Planning, Funding and Accountability Manual* which provides guidelines for all long-term care community services agencies.

Lastly, it is expected that CCACs adhere to acknowledged standard business practices.

Contracting

The ministry contracts with a CCAC through a service agreement comprised of a service plan, budget, and legal agreement. Until a new service agreement is signed, the preceding signed agreement is in effect. The agency and its board are also expected to have contracts with service providers and suppliers, staff, etc.

Monitoring and Reporting

CCACs are expected to gather information to monitor their performance in a number of ways. These include: staff performance reviews; statistical analyses of service utilization and financial reports (provided to the ministry monthly); reviews of the accuracy of billings by suppliers; and processes to monitor the quality of services provided to clients.

In addition to local activities at the CCAC, the ministry provides *Provincial Management Information Reports* to CCACs. These reports provide CCACs with useful information to enable them to assess their performance relative to other CCACs. These quarterly reports include:

- *Service Indicator Report* – reports service utilization for in-home services in relation to CCAC clients receiving service and to the total population in a geographic area;

- *Resource Allocation Report* – reports overall resource allocation and financial indicators based on approved budgeted service utilization, budgeted clients using indicated services and total population;

- *Resource Utilization Report* – reports overall resource allocation and financial indicators based on actual service utilization, actual clients using indicated services and total population;

- *Waiting List Statistics* – "snapshot" reports on the number of people identified as waiting for in-home services and/or placement at the end of a three-month period.

Through the reports, CCACs can be compared with CCACs in their region and with "peer" CCACs serving similar areas.

A Best Practices Project (BPP), of the ministry and the CCAC provincial association, is building the foundation for the development of benchmarks and best practices. The Project's newsletter is recognized as a valuable tool in disseminating information to all CCACs about individual program best practices and innovative ways of meeting the needs of clients.

Corrective Action

Corrective action must follow the monitoring process when that process identifies problems. Without this final step, the monitoring is of little value.

Further methodology specific to the areas of review is reported at the beginning of the respective sections.

PROGRAM REVIEW

Case Management

The largest element of a CCAC's activity is its home care service. The primary vehicle for a CCAC to carry out the home care portion of its mandate is through its case management services, a core business function of a CCAC.

The case management business of a CCAC is centered on the authority vested in case managers to authorize all CCAC services. Government relies on case managers to ensure that the right services are provided to the right clients, that services are adjusted according to the clients' needs, and that clients are discharged as soon as the services are no longer required to meet the home care service goals.

After a thorough review process that included a review of manuals and client files, and interviews with staff and selected external parties, the overall impression of HWCCAC's case management could be summed up in one word - "disarray."

HWCCAC inherited case management that was experienced but not as rigorous as it should have been; however, the function of case management has declined under the HWCCAC. Unless significant changes are made in the near future, there will be further deterioration of the case management services with a subsequent impact on client services and a continued growth in the deficit.

Senior management is not paying serious attention to the key functions of case management. These functions are outlined in the *Ontario Home Care Manual, 1984*, and include:

- assessment and determination of eligibility,
- alternative service planning for individuals not eligible for CCAC services,
- goal setting,
- service plan development to achieve the goals,
- authorization of the client's initial plan of service, including all services, medical supplies and equipment,
- monitoring and reassessment of the client's needs and eligibility,
- adjusting the client's service plan as required,
- planning for discharge ,
- community relations – providing information about CCAC services to the public and other service partners.

From a resource management perspective, the most important responsibilities of case management are: eligibility determination; assessment of clients' needs; authorization of the initial plan of service; and timely reassessments to adapt services to increasing or decreasing client needs. All subsequent expenses flow from these processes. As noted below, the performance of the HWCCAC is fundamentally weak in these critical responsibilities.

The recent labour disputes and the subsequent restructuring exacerbated a case management system that was already struggling. There have been frequent senior management changes, high caseloads, media scrutiny and a perception that management was not responding to case managers' concerns.

Review Process

Interviews were conducted with:

- Two groups of front-line case management staff, including community case managers, hospital case managers, speciality (e.g., ABI, palliative care, paediatric) case managers and intake case managers,
- Senior managers with client service responsibilities,
- All middle managers with client service responsibilities. The above-mentioned front-line case managers report to and are accountable to this group of middle managers,
- Union representative who is a Case Manager Assistant,
- External people who have links to hospital discharge planning, long-term care facilities, and the CCAC.

In addition, information from interviews between ministry staff and HWCCAC senior management was integrated into this review process

Document Review

Manuals:

- *HWCCAC Case Management Orientation Binder*
- *HWCCAC Community and Client Services Manual, March 2000* (not yet implemented)

Client Files:

A statistically significant number of randomly selected files of current and discharged clients (more than 200), including files for school health support services were reviewed.

The Ministry Review Team was impressed with the responsiveness of staff to requests for information and appreciated the cooperation and assistance provided throughout the review process.

The case management review is outlined under the following four headings:

- Service Utilization Management
- Case Management
- Organizational Pressures
- HWCCAC System Redesign

Service Utilization Management

Observations

The total amount of homemaking and therapy services provided by the HWCCAC has increased markedly over the course of the year 2000. The impact of this on the deficit has been largely unrecognized by the HWCCAC senior management and board.

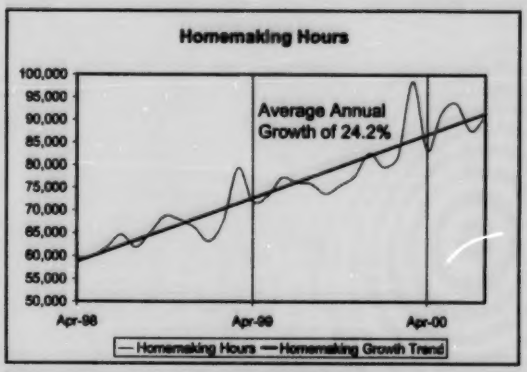
Volume Increases
1999/2000 over Prior Year

	Hamilton-Wentworth	Comparators*	Provincial Average
Homemaking	20 %	4 %	11 %
Nursing	10 %	2 %	9 %
Therapy	10 %	17 %	13 %

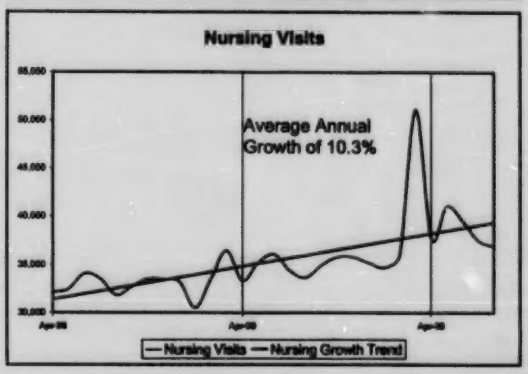
* Niagara, Windsor-Essex, Ottawa-Carleton, Toronto

The chart above demonstrates that utilization in homemaking and nursing has increased dramatically for HWCCAC compared against a group of their peers. Although therapy has increased less than the comparator group, the table does not illustrate the already high service levels prevalent at the HWCCAC.

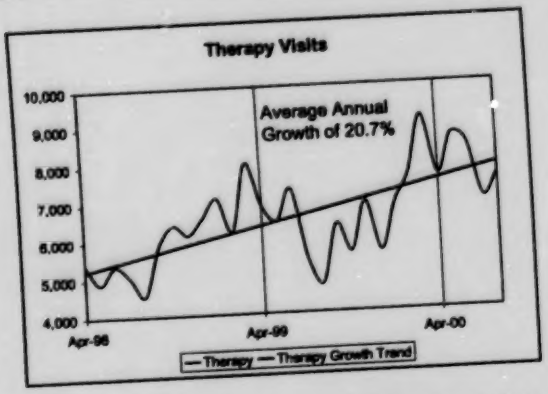
The following charts demonstrate this growth over a two-year period.



This chart demonstrates significant growth in homemaking services, averaging more than 24% annually. In addition, the impact of reconciling against billed services rather than ordered service is dramatically demonstrated in the surges seen in the report for March (year-end).



Significant increases in nursing visits are demonstrated, although increases were less than that of homemaking. The impact of reporting billed services rather than ordered services is particularly evident in March 2000.

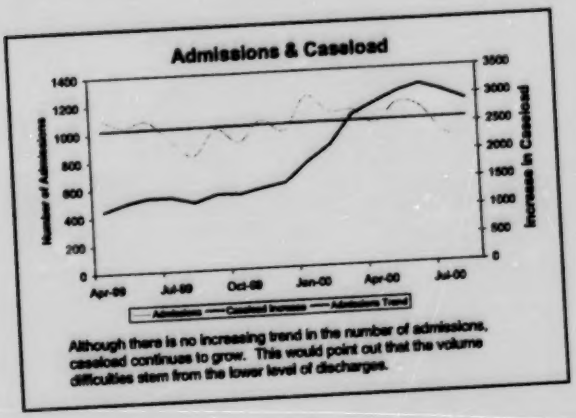


The volume of therapy visits also escalated sharply.

The costs for homemaking and therapy services attributable to volume increase greatly exceeded the funding increases, and contributed to the deficit.

In addition, based upon the January 2001 forecast provided by the CCAC, the following growth in volumes was projected: Homemaking – 17.1%; Nursing – 1.7%; Therapy – 23.4%.

The next graph demonstrates the "snowball" effect on the caseload as described in the "Introduction" section.



A review of admissions and caseload demonstrate that although admissions are relatively constant over the past two years, caseload is increasing substantially. This happens when the number of discharges does not keep pace with admissions and the average length of stay on the service increases.

The HWCCAC explained the cause of growth in caseload and service utilization volumes in terms of uniqueness of the Hamilton-Wentworth community. Factors identified by the HWCCAC as being unique to the community they serve include: the percentage of seniors aged 65 years and older (which is captured in the Equity Funding Formula); socio-economic status; and a high number of seniors living alone in the community.

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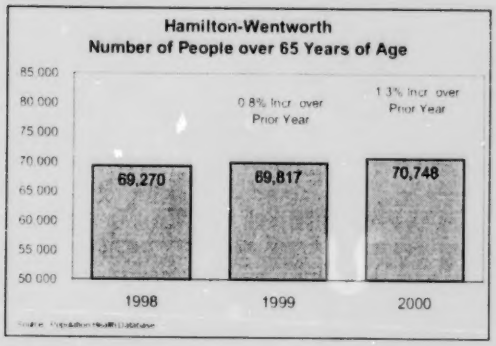
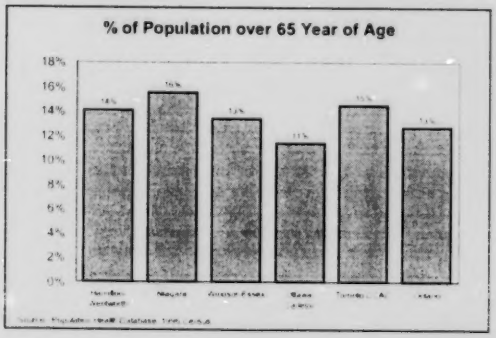
The following charts do not support these arguments. When these *"unique"* factors are compared with other communities in Ontario, the uniqueness of these aspects of the Hamilton-Wentworth community are not in evidence and cannot be supported as justification for the dramatic growth in service volumes.

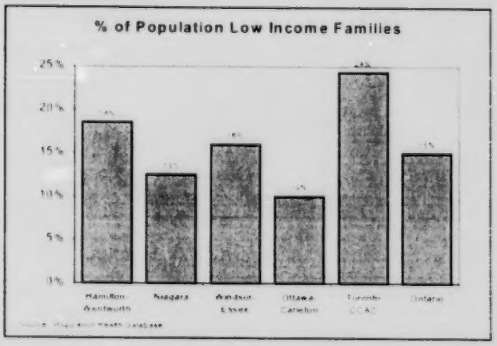
The growth in seniors, i.e. population over 65 was only about 2% in Hamilton-Wentworth over the past two years - well below not only the substantial funding increase received by the CCAC (17.8%), but also well below the double digit growth they are reporting in homemaking, therapies and nursing as demonstrated above.



The Hamilton-Wentworth percentage of population greater than 65 years of age is only slightly higher than the Ontario average, i.e. about 1% higher.



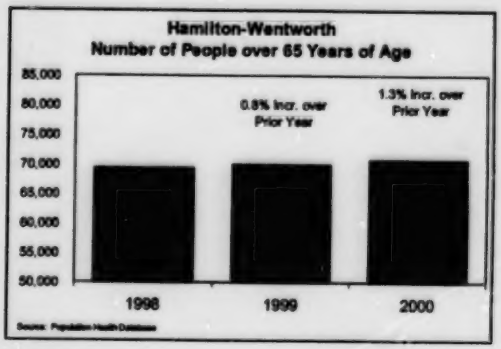
The percent of the population over 65 living alone is marginally higher than the provincial average, i.e. approximately 2%. This chart demonstrates at least 2 communities among the comparator group that have significantly higher percentages of seniors living alone. The CCACs serving these populations however, do not demonstrate growth pressures of the magnitude seen at the HWCCAC.



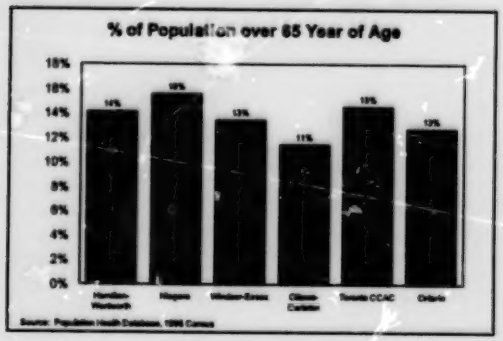
The percentage of low-income families is about 25% greater than the provincial average. However, this factor alone does not justify the double-digit increases in service volumes.

The following charts do not support these arguments. When these *"unique"* factors are compared with other communities in Ontario, the uniqueness of these aspects of the Hamilton-Wentworth community are not in evidence and cannot be supported as justification for the dramatic growth in service volumes.

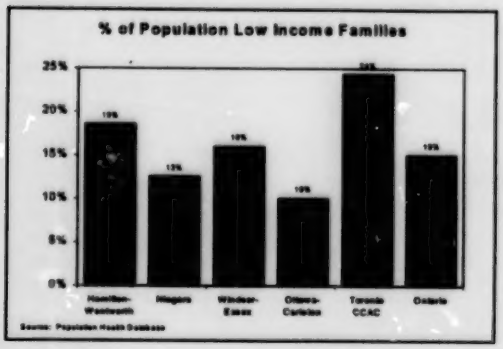
The growth in seniors, i.e. population over 65 was only about 2% in Hamilton-Wentworth over the past two years - well below not only the substantial funding increase received by the CCAC (17.8%), but also well below the double digit growth they are reporting in homemaking, therapies and nursing as demonstrated above.



The Hamilton-Wentworth percentage of population greater than 65 years of age is only slightly higher than the Ontario average, i.e. about 1% higher.



The percent of the population over 65 living alone is marginally higher than the provincial average, i.e. approximately 2%. This chart demonstrates at least 2 communities among the comparator group that have significantly higher percentages of seniors living alone. The CCACs serving these populations however, do not demonstrate growth pressures of the magnitude seen at the HWCCAC.



The percentage of low-income families is about 25% greater than the provincial average. However, this factor alone does not justify the double-digit increases in service volumes.

A rate volume analysis was performed to determine key drivers behind the mounting deficit at the HWCCAC. The chart opposite breaks out cost pressures attributable to:

- volumes – the pressure caused by increasing the amount of services delivered
- rates – the pressure caused by increasing rates paid to providers.

Increases in Revised Budget due to Rate & Volume Changes in Purchased Services

	HM	Nursing	Therapy
Rates	$1.2 M	($0.04) M	$1.3 M
Volumes	$2.4 M	$0.9 M	$0.6 M

Total due to Rates	$2.5 M
Total due to Volume	$3.8M
Purchased Service Increase	$6.3 M

The Stabilization & Equity Funding of $3.3 M addresses the CCAC's rate pressures. Increases in volumes are causing the budget problems

The chart reveals that the substantial driver of the deficit is the increasing volumes. Funding provided by the ministry was sufficient to address costs pressures attributable to increased rates for service delivery. In fact, $800K in funding was available for other projects after the funding for rate increases had been taken into account.

No level of the HWCCAC monitors service delivery through the use of effective service utilization targets to ensure expenditure growth is consistent with the growth in funding. There was no evidence of an effective strategy to correct excessive expenditures.

There was an ineffective process for prioritizing clients for services. The current system was described as frequently amounting to "*clerical staff putting referrals into piles.*" This is relevant not only to utilization of services, but more importantly to prioritization of clients whose health care needs are greatest.

The HWCCAC's response to service monitoring issues focuses on the inadequacies of CASIS, their case management information system. Undoubtedly CASIS is not adequate for a program with substantial volumes; however, it is not fiscally responsible to spend approximately $1 M a week and not have any form of service utilization targets and/or controls in place. In businesses where data monitoring is of such vital importance even the best automated information management systems also require some form of back-up mechanism in the event of a computer system failure. It is important to note, however, that CASIS has been in place for many years and until recently services were provided at costs close to budget allocations.

It is apparent that senior management does not fully appreciate the serious need for service utilization controls and has not provided any substantive strategies to staff to monitor and control utilization.

Middle managers recognize the need for service utilization controls; however, they also focus on the deficiencies of CASIS rather than the use of alternative strategies. Although they are advised of the service utilization trends, middle managers are not involved in service utilization monitoring or correction strategies.

Case management staff are not provided with service utilization targets. Although there is a management approval process for provision of higher service levels this is a crude and

evidently ineffective method of control. It does not allow case managers to exercise their responsibilities under policy and reduces their ability to effectively plan and meet client needs.

Management has provided financial information about the deficit to case managers but has not involved these experienced staff in finding ways to correct the problem.

Recommendations

1. Implement a system immediately for support staff to manually track admissions, discharges, caseload and services ordered until improvements/upgrade of the automated information are available. If this is done within small units of the organization (either by each case manager or by each team), it is manageable and has the added benefit of identifying and targeting corrections that are needed for both process and personnel. A weekly roll-up should be provided to management for monitoring and ensuring corrective action is taken.

2. Improve the system of prioritization of clients for services. The function requires the expertise of a health care professional.

3. Provide middle management, case management staff and the ministry's regional office with manual bi-weekly reports, developed from the above recommendation, showing plans for and progress toward deficit reduction until such time that automated, up-to-date and accurate service utilization information is reliably available.

4. Use expertise available from other CCACs that are managing service utilization well, especially those that have knowledge of manual information monitoring methods. By tracking the following information by case manager or by team, major activity can be monitored:

    - Admissions and discharges (from which caseload can be calculated),
    - Changes to homemaking hours ordered,
    - Changes to nursing visits ordered.

    Changes to therapy services ordered are not usually a major concern because the total costs are normally a small portion of the overall budget. However, since the growth in these services at HWCCAC has been identified as contributing to the deficit it would be wise to track these costs too, at least until the growth is contained within the approved funding.

Case Management Functions

This section will cover a review of case management practices prior to the labour disputes.

Documentation

Observations

The scope of review of client files included discharged clients, current clients, homemaking-only clients, and school health support service clients.

The overall objective of the client file audit process was to determine whether the file reflects adherence to the *Health Insurance Act* and the *Long-Term Care Act, 1994*. The intent is to ensure there is a "paper trail" to justify the client's eligibility for service, service planning and authorization, monitoring and reassessments, timely corrections to the service plan and evidence to support the appropriateness and promptness of discharge from the service. The documentation is important to demonstrate responsiveness to client needs and accountability to the public.

HWCCAC case managers use both a paper file and a CASIS file to provide complete client information. This is an unwieldy and convoluted method for storing and retrieving client information.

Given the inadequacies of the client file system, the longer term issue is the requirement for a new system that will be both user friendly for case managers and provide easy access to client files by management staff for monitoring purposes. However, the following comments are directed at client record issues that can be addressed in the short term.

- Client eligibility for services did not comply with the *Health Insurance Act*. Usually the only evidence found in files was a Health Card number.
- Forms were not completed - there were many blanks where "N/A" (not applicable) was not used to demonstrate that criteria had been assessed.
- Entries documenting clients' consent to the sharing of information were rare.
- In service planning, there was little reference to the establishment of goals. The general goal of helping clients to be as independent as possible is particularly salient to service utilization.
- Reassessments could not be tracked. Several parties acknowledged that the planned reassessment dates "aren't real." It appears a long-term date was given for the reassessment and then the case manager would reassess if and when there was an opportunity.
- A description of the informal caregiver's role and what support they needed was rarely identified. Usually, all that was indicated was who had the role of informal caregiver.
- A client risk assessment tool was not in evidence.
- Teaching of clients or family members to do procedures was rarely mentioned. Service providers are expected to teach procedures to family members or other informal caregivers, where possible and appropriate, to prevent unnecessary service costs.
- Revisions to the client service plan were difficult to track.

Discharge planning is difficult to track. Discharge planning should begin soon after a client's admission for services; however, typically there was only a discharge report following a client's discharge.

Recommendations

5. Initiate development of a simple method for documenting client eligibility (e.g., a tick box for each eligibility criterion) and a section to indicate the client has been informed of the complaint/appeal process.

6. Document consent clearly in each client's file.

7. Clarify notations in CASIS classifying information as "Intake," "Assessment," "Initial Service Plan," "Reassessment," "Service Plan Adjustments," and "Discharge Planning."

8. Document revisions and rationale for changes to the client service plan (e.g., change in nursing visits).

9. Outline expectations for staff regarding professional documentation standards for client records (including eligibility). Include the year for all dates recorded. These requirements must be included in case managers' performance plans and annual reviews.

10. Provide a risk management tool that incorporates the material presented in the *HWCCAC Community and Client Services Manual* (dated March 2000 - prepared prior to the operational review but not implemented at the time of the review).

11. Ensure the *HWCCAC Community and Client Services Manual* (March 2000) shows:

    - linkages between the *Long-Term Care Act, 1994,* and HWCCAC policies, e.g. development of a plan of service (Section 22), plan for dealing with situations of suspected client abuse (Section 26), waiting list (Section 23), consents (Section 24), and quality management (Section 27),

    - linkages between the *Health Insurance Act* and CCAC services, e.g. eligibility for transportation services, lab services, etc.,

    - regulations under the *Long-Term Care Act,* e.g., regulations for service maximums and for provision of service in private and home schools, etc. (*Regulation 494/00 and Regulation 677/00*).

12. Include the above recommendations in the *HWCCAC Case Management Orientation Binder.*

13. Expand the Case Management Model in the *HWCCAC Case Management Orientation Binder* to include the full range of case management responsibilities, as outlined in the *Ontario Home Care Policies and Procedures Manual.*

14. Other recommendations for the *HWCCAC Community and Client Services Manual*:

    - Amend the Appeal Policy to reflect the role of the Health Services Review Appeal Board.
    - Amend the Alternative Medical Supports Policy to reflect the *Health Insurance Act.*
    - Amend the School Services section to include information and policies about the provision of CCAC services in private and home schools.
    - Amend the Equipment Policy to reflect the *Health Insurance Act.*

15. Implement the new *Community and Client Services Manual (March 2000)* immediately (upon completion of revisions) through a training process that includes case managers and case manager assistants.

Authorization of Services

Observations

The most frequently raised issue by case managers and others was the need for consistent messages from management, particularly messages about the amount of service that a case manager can authorize.

The fundamental issue is that the messages are not grounded in *Regulation 386/99* of the *Long-Term Care Act, 1994*. It is noteworthy that this regulation is not provided in the *Community and Client Services Manual (March 2000)*; and the local policy in the manual does not reflect the entire regulation. Compliance with regulations is a requirement of the *Long-Term Care Act, Section 22 (7).*

A second identified issue related to authorization was the often repeated comment that if a client complained about the level of service, management invariably told case management to give the client what they had requested. This concern was voiced by both community and hospital case managers. The perception was that management wanted to avoid any client appeals. Case managers feel unsupported when they make decisions that they believe reflect the assessed level of need and then management, without a thorough review, overturns their decisions. This undermines the case manager role and is a failure of the CCAC's responsibility to assess needs as opposed to wants, and to manage resources.

Recommendations

16. Provide clear and consistent information about eligibility criteria, goal setting and service planning using current legislation (Section 22 of the *Long-Term Care Act)*, regulations, provincial policy, case studies and a decision tree in the orientation and training for case managers.

17. Distribute to discharge planning staff and social work staff in local hospitals information that details HWCCAC services, including eligibility criteria, service maximums, and service planning. Included in the document should be a copy of *Regulation 386/99* of the *Long-Term Care Act, 1994* that outlines service maximums for nursing, homemaking and personal support and eligibility criteria for homemaking.

Observations

Authorization of therapy services is inadequate. The case manager only indicates the client's priority and authorizes an open-ended service plan. Comments such as, *"it's a hands-off approach"* and *"usually authorize more than needed on the assumption the therapist will only provide what's needed"* are of concern. Leaving these service decisions to the service provider creates a conflict of interest with the potential for providing more services than necessary.

Recommendations

18. Direct case managers to authorize individualized service plans for all clients requiring therapy services (Section 22 (1) (c) *Long-Term Care Act)*. An exception would be where there are established clinical pathway protocols.

19. Use case managers and managers with a clinical background in rehabilitation, as clinical advisors to case management staff in matters related to contentious therapy issues.

Observations

The local HWCCAC policy for authorization of services for clients living in rest and retirement homes is inconsistent with provincial policy. HWCCAC only authorizes homemaking services to a maximum of 0.5 hours in the morning and evening. Provincial policy requires that clients living in a rest and retirement home be assessed for eligibility for the service maximums as defined in *Regulation 386/99* of the *Long-Term Care Act*.

Recommendation

20. Change local policy and direct case managers to assess all rest and retirement home clients for eligibility for services in accordance with the service maximums defined in *Regulation 386/99* of the *Long-Term Care Act*.

Observations

The files for provision of school health support services included clear and comprehensive case conference notes by the HWCCAC case manager. However, the service plan was documented on school board forms. The perception is that the school board has determined what service is required, the frequency of the service and the goals of each service. CCAC case managers are required to authorize and develop the service plans of all clients (Section 22 of the *Long-Term Care Act)*.

Recommendation

21. Discontinue use of the current school board forms describing the authorized service plan. HWCCAC should be developing its own forms to document functions that are within its responsibilities. The school board form must clearly indicate it is purely a referral/application for service.

Implementation of the Service Plan

From a client services perspective, the process for implementation of the authorized service plan raises the most serious concerns.

As noted above, many files were reviewed. In one exercise ten randomly selected active client files were reviewed from both paper and CASIS file perspectives, to determine if services were provided as planned. The clients' admission dates included 1995, 1997, 1998, 1999, and 2000. Of the ten files, five (50%) suggested that clients did not receive the services authorized. The five examples are:

1. Nursing, physiotherapy and personal support/homemaking was authorized on the initial service plan but for a one year period there was no evidence that nursing had been provided. There was no explanation in notations.

2. Nutrition and speech services were authorized on the initial service plan but there was no evidence that speech therapy was provided. There was no explanation in notations.

3. Occupational therapy was authorized and there was no evidence that the service was provided. There was no explanation in notations.

4. Physiotherapy, occupational therapy, and personal support/homemaking were authorized on the initial service plan but there was no evidence that physiotherapy was provided. There was no explanation in notations.

5. Nursing, physiotherapy and personal support/homemaking was authorized on the initial service plan. Two nursing agencies received the referral and both made a visit.

In addition, in our interviews with external sources and with case managers, concerns were raised about implementation of CCAC service plans. Case managers spoke generally about a lack of confidence that services would be provided to the client as authorized in the service plan. Case managers stated that they have expressed concerns to management about client safety and the possibility of negative consequences for them personally because of their perception of their accountability to the College of Nurses.

The external interviewees spoke specifically about clients who (pre-strike) were discharged from hospital with a CCAC service plan that never materialized. In one instance, it was an elderly gentleman, and the other client was a young woman who went home to receive palliative care services. The gentleman returned to the hospital emergency department 10 days later. The woman returned to hospital a week later and declined the option to return home with another HWCCAC service plan. Several follow-up telephone calls to the HWCCAC apparently did not resolve why the service plans were not implemented.

Clearly, there is a flaw in the process for implementation of HWCCAC service plans.

Recommendations

22. Direct, on an urgent basis, case management assistants to provide a follow-up telephone call to each new admission to ensure that each component of the service plan has been implemented. Ensure that clients know how to reach their case manager in the future if there is a problem. In addition, a follow-up phone call should be made to other CCACs that have been sent a HWCCAC referral for clients returning to their home areas from Hamilton.

23. Enlist the assistance of HWCCAC service providers to identify ways to improve the implementation process.

24. Review all aspects of the implementation process for service plans and initiate a new system that includes quality controls.

Monitoring and Reassessment

From a client service perspective, it is important that services be increased as soon as the needs increase; and from a financial perspective, it is important that services be decreased as soon as the needs decrease.

One extra visit per client can have a large impact on expenditures. For example, if half of HWCCAC clients (5,000) receive only one unnecessary visit (at an average cost of $50 for example) because discharge was not as soon as possible, the financial cost is $250,000. Usually a slow discharge process means that more than one extra visit occurs, so savings would be significantly higher. Not only would this help keep expenditures within resources but it would free up funds to provide services to other clients with greater needs. It is significant that, during the VON strike, it was found that about one third of the clients could be discharged from nursing services. This further suggests that

the caseload growth and size is greater than it needs to be, or would be if rigorous monitoring was being done.

Timely written and verbal reports from service providers, telephone calls to the client, home visits, etc., are essential elements of monitoring and reassessment.

Observations

Both management and case management indicated that it was understood that reassessments, particularly home visits, are an important mechanism for ensuring ongoing eligibility for service, that the right amount of service is provided, and that discharge is timely. However, both management and case management acknowledge that limited monitoring is done and reassessments are not timely. Large caseloads are a factor, but they are probably unnecessarily large as suggested above.

The client file review indicated that planned reassessment dates are not thoughtfully considered and that reassessments occur infrequently.

Therapy providers do not seem to provide any additional reporting after the initial assessment (other than the discharge report). It seems that therapy providers make their own determinations about ongoing service levels and length of service.

A review of CCAC documentation identifies inconsistent direction from senior management with regard to client reassessments. Although the schedule for client reassessment has been identified in the past as every six months, this is not reinforced or monitored by management. During the review of client files it was noted that there was no consistency in the pattern of reassessment. Without regular client reassessment activity, it is not possible to ensure that service levels have been adjusted according to client needs. Delays in reassessment may also reduce the number of service discharges thereby compounding the increase in the client caseload. As long as client discharges do not keep pace with admissions, the client caseload will continue to escalate. See chart on page 17.

Experience gained during the VON strike action in September would support the need for HWCCAC to greatly improve its reassessment of clients. HWCCAC statistics indicate that one third of the VON nursing caseload was found not to require regular nursing services following a case review. Another third could be managed by telephone calls or outpatient services and may therefore have been ineligible for home care.

VON STRIKE EXPERIENCE

Of 1800 Clients on August 17, 2000

- **600** Discharged
- **600** Ambulatory Care Clinics or Phone Contact
- **600** Transferred to Other Agencies

Recommendations

25. Implement a strategy to ensure timely reassessments, with frequency tailored to the needs of each client (Section 22 (2) of the *Long-Term Care Act).*

26. There is no "magic number" for an ideal caseload; however, conventional wisdom is that an average of 120 clients per case manager is the ***maximum*** for a caseload with varied clients. The HWCCAC ratio at the time of the review was higher than this. Every effort should be made to include the necessary case managers in budgets, and to maintain the staffing at approved budget levels. It might also be possible to temporarily increase the number of case management staff to complete the outstanding reassessments, and thus reduce the caseload and make the workload more manageable for the existing staff. A reduced caseload might also relieve pressure on the information system.

27. Implement a well-defined mechanism for case managers and therapy service providers to communicate with one another. The reporting system should include more than an assessment and discharge report. More frequent and timely information is mandatory so that case managers can effectively monitor progress towards goals, reassess needs, and adjust services.

Organizational Pressures

Observations

There are a number of sources of stress in the organization. Senior management changes, culture differences between some of the board/senior management and staff, substantial organizational changes, a significant deficit, media scrutiny and high caseloads contribute to the organizational pressure.

While the labour dispute may have enhanced cohesiveness among the senior management team, it has also intensified the poor relationship between management and staff.

At no time did management indicate that they value their case managers and understand the difficulty of the role. Case managers verbalized their distrust of management's leadership and their deep concern about feeling unsupported by management.

There was no evidence that senior management had implemented measures to respond to the continuing deterioration in relationships between staff and management. Clearly, this deep divide has to be addressed. There is a pervasive atmosphere of distrust and discontent.

Recommendations

28. Undertake an organizational development process with a strong focus on team building.

29. Involve staff in identifying sources of stress and implement stress-reduction strategies.

30. Management should demonstrate to case managers their recognition of the value and difficulty of the case manager's role. One way to demonstrate this would be to avoid arbitrarily reversing case manager decisions about client services.

31. Implement an annual performance appraisal system for case managers. Monitor through a quality control mechanism.

32. Arrange an in-service by the College of Nurses of Ontario on professional accountability for management, case managers and case manager assistants.

The objective of the in-service would be for those case managers who are registered with the College of Nurses of Ontario to have a confident understanding of their accountability to the college. At the same time, the college might be able to provide information to the CCAC on the legal requirements for maintaining client/patient records.

HWCCAC System Redesign

Implementation

In spring 2000, there was a survey of staff, apparently to assist with developing a plan to restructure the organization.

When the labour dispute ended in December 2000, management implemented the new structure without any follow-up to the spring 2000 survey. There is minimal documentation describing the new structure. There is also no documentation of a well-planned transition.

Case management staff at hospitals and community case managers were assigned new responsibilities with minimal orientation and no transition process; no phasing-in, no substantive orientation to their new hospitals about protocols, processes, etc.

This major change in structure has led to a high degree of case management stress and concern about provision of client services. Staff expressed confidence in their general understanding of case management functions; however, the sudden change in roles, assignments and settings without adequate orientation was identified as the major source of stress.

Hospital staff were invited to an in-service about the changes but expressed confusion and frustration about the new method of access to CCAC services. At the in-service no materials were provided although a commitment was made to provide a resource binder. A week later the binder had not been received by hospital staff.

Comments received from hospitals and neighbouring CCACs indicate concern about the level of assessment and the inadequate information to support service plan implementation.

Recommendation

33. Focus immediately on ensuring that all case managers have an opportunity to identify and meet their needs for orientation to their new assignments.

Changes to Case Manager Roles

In addition to the inadequacies of the implementation process, the restructuring plan raises serious concerns about management's dilution of the authority of the case management role.

As mentioned earlier, the business of a CCAC is centred on the authority vested in case managers. Government relies on the CCAC's case management to ensure that the right services are provided to the right clients, that services are adjusted according to the client's needs, and that clients are discharged as soon as the services are no longer required (Section 22 of the *Long-Term Care Act).*

As part of the redesign, the case management role in hospitals has been significantly changed. Instead of all referrals being assessed by a case manager, "routine and single service referrals" are to be accepted from the hospital staff for service implementation by the CCAC intake. This means that the hospital staff will, in essence, be determining eligibility for CCAC services and authorizing the initial service plan. This is not an acceptable practice. Hospital staff are not accountable for CCAC expenditures and they do not have expertise in service provision in the home setting.

HWCCAC serves 10,000 clients annually and at least 60% of the referrals are from the hospital setting. The impact of this dilution of the HWCCAC's assessment and service authorization role seriously reduces its accountability. Access to CCAC services from the hospital setting must be through case managers fulfilling their key responsibilities.

In exceptional circumstances, some case manager functions can be delegated in order to provide flexibility. Typically, the functions would be delegated to a service provider. An example is that a CCAC may negotiate with a nursing provider agency that has a clinical nurse specialist to provide ongoing case management for a client in an exceptionally complex situation. These service provider agencies have contractual obligations to the CCAC, which can include specific accountability measures. In addition, agreed-upon clinical pathways can be used to articulate a client's service plan in routine situations such as hip fractures.

The new role of the HWCCAC hospital case manager is portrayed as a "consultant" (with the exception of the case manager in the emergency department). The perception is that she is primarily on-site to provide information to hospital staff. There is not a perception that assessment and eligibility determination and service plan authorization are primary responsibilities.

Community case managers are now expected to go to the hospitals to attend team conferences and family meetings about any of their clients.

Changes have also taken place in the function of intake/information and referral. However, there is a significant lack of clarity about the plan. In several meetings, members of the review team asked questions about the changes, but received inconsistent answers and were told that everything was "in transition." There was a general lack of understanding by all parties about the new configuration and individual roles.

Recommendations

34. Focus on the implementation of an effective case management system.

35. Take immediate steps to ensure that all referred hospital patients are assessed for eligibility and service needs by CCAC case managers.

36. Eliminate the new title of "Consultant Case Manager" and restore the "Case Manager" title.

    The hospital case manager has a more authoritative role than that of a "resource" and a provider of information. It is important that hospital staff receive clear and firm messages about case management responsibilities and authority.

37. Reconsider the extent to which community case managers need to attend regular meetings in the hospital setting.

    Community case manager caseloads are generally quite high, and monitoring/ reassessment practices are acknowledged by case management and management to be inadequate. The time required to attend unnecessary meetings in hospitals could impede improvement in monitoring and reassessment practices.

Authorization of Equipment

Service providers will now send their requests for equipment directly to the vendor. The CCAC is accountable for equipment expenditures but has given the control of expenditures to non-CCAC staff.

Recommendations

38. Ensure that case managers authorize all equipment before it is ordered *(*Section 22 (1) (c*)* of the *Long-Term Care Act).*

39. Grant case managers responsibility for deciding when equipment is to be removed from the client's home.

Placement Services

The CCAC has the responsibility of providing access to beds in long-term care facilities. This role includes the functions of assessing to determine eligibility for placement into a long-term care facility, managing the waiting list for facility placement and authorizing

clients' admission to vacant facility beds. Requirements for this role are identified in the ministry's *Placement Coordination Services Manual, The Long-Term Care Act (1994)* and *An Act to Amend Certain Acts Concerning Long-Term Care (1993).*

The review of placement services was conducted to establish whether the HWCCAC is providing placement services that are consistent with relevant legislation and policy. The review process included the review of client placement files and discussions with the staff and manager responsible for placement services.

As mentioned in the previous section on case management functions, inadequacies in the client record system and documentation made the process of file review difficult. In each file reviewed, eligibility for placement was verified in a letter to the client or substitute decision-maker; however, the basis for determining eligibility was not always clear. The impression received by the reviewers in discussions with a number of parties was that everyone who applied for admission to a facility was found to be eligible. Provincial policy requires that all possible options for community services, including supportive housing, should be explored before clients are declared eligible for placement in a facility.

Although the provision of community services to clients awaiting or applying for placement was noted, it was not always evident what services were provided nor whether services were provided in the maximum possible amounts where necessary to allow the person to remain in the community. In some files, an eligibility checklist was included; however, this was not consistent across all files reviewed.

The process of determining priority classification for placement is also a function of the CCAC. The *Placement Coordination Services Manual* requires the CCAC to have a process to identify people in a crisis situation and make them the highest priority for placement. Although the file review did indicate that individuals were identified as being in crisis, how this determination was made was not clear. Discussions with placement staff identified that there was not a specific criterion used by case managers to determine crisis status but that if the family claimed there was a crisis, it was accepted as such. Case managers would consider the definition in the placement policy manual and case studies as examples. The HWCCAC has not established a specific local definition of crisis as required under policy.

In the summer of 2000, the ministry determined that veterans who are eligible for long-term care facility placement should be given priority access to beds. The ministry provided training for CCAC placement staff in the summer, with the expectation that CCACs would identify individuals who would be eligible for the priority beds and would manage the wait list for placement into the designated veteran beds in their area accordingly. At the time of this review, the HWCCAC had not initiated a process to identify those veterans on the wait list who may be eligible for the priority access beds.

All client files reviewed included a facility choice checklist provided by the client or substitute decision-maker. However, there was no indication of response from the facilities chosen as to whether the person had been accepted by the facilities, and

subsequently placed on the respective facility wait lists. As per legislation, all facilities are required to confirm to the CCAC their decision to accept the person on their wait list within five working days of receiving the application from the CCAC. This process allows facilities to identify whether they are in a position to meet the care needs of the individuals seeking their services. The process also confirms for the client which facilities they are being considered for placement within. Without the facilities' confirmation of acceptance, it is possible that confusion could exist about whether the person is on certain facility wait lists.

Legislation requires that clients waiting for placement in a long-term care facility be reassessed at least every six months to ensure that facilities that have accepted people are aware of any changes in the person's care requirements. This enables facilities to reassess their ability to meet the care needs of the individual. Although CCAC reassessments were seen in the chart review, a regular pattern of six-month intervals was not found. In discussion with placement staff, staff explained that updated assessment information was not always available within the six-month time frame but that updated information would be obtained if the person were being actively considered for a bed offer.

Recommendations

40. Revise placement processes to ensure consistency with current legislation, policy, and program standards.

41. Establish a clear definition of crisis status based upon local factors as identified within the ministry's *Placement Coordination Services Manual.*

42. Implement a process to identify veterans who would be eligible for priority access beds and establish a wait list for this purpose.

Nursing Clinic Operations

The HWCCAC has operated a community health care clinic for providing some nursing care since it's inception in 1997. The operation of this clinic was established by the VON – Hamilton, the previous administrator of home care services. The number of nursing clinics was increased to seven as a strategy for managing service delivery during the VON nurses strike. The nursing clinics provide services for people who are ambulatory, as an option to services in their home setting. Nursing services provided in the clinic setting include:

- intravenous therapy
- catheter care
- ostomy care
- injections
- subcutaneous butterfly changes
- diabetes education
- ambulatory pump care

- wound care

Individuals are identified by service intake or case management staff and, if deemed to be appropriate for this option, are informed of the option and given the chance to choose home or clinic service. Discussions with case managers indicated that if people were deemed appropriate for clinic care they would be encouraged to choose this option, where possible. Although people are assessed through the access team or the case management staff for suitability for clinic services, they do not receive follow up reassessment from a case manager. Decisions about changes to the frequency of services, and about discharges, are made by the service provider's nurses at the clinic.

These nursing clinics had been established as a pilot program to determine the viability of this method of service delivery on a long-term basis. Regulations governing the provisions of nursing services by the CCAC do not support service delivery in a clinic setting. In fact, people who are able to attend outpatient facilities are not normally eligible for CCAC services.

The CCAC has conducted two analyses of the clinics, the first in November 1999 and the second in September 2000. The CCAC reports that the analyses suggest the clinics provide a cost savings for the delivery of nursing services and that clients surveyed identified that they were pleased with the option of clinic service and were satisfied with the care they received.

Recommendations

43. Case managers should determine the initial and ongoing eligibility of clinic clients and should authorize changes to service levels.

44. Conduct a detailed assessment of long term cost savings through the operations of the clinic and include an assessment of whether all clients served are eligible for CCAC services according to provincial eligibility criteria.

45. Continue the clinic pilot project. Further expansion, however, should not be considered until the ministry has had an opportunity to assess the long-term appropriateness of clinic operations.

MANAGEMENT REVIEW

The management of an organization is responsible for its day-to-day operations. Accordingly, the issues raised earlier in this report reflect on the HWCCAC's management, except in the case where managers are acting on directions from their board or supervisors.

Review Process

Information for the review of the HWCCAC management and organizational structure was obtained through a combination of interviews with staff and a review of relevant documentation. Individual interviews were conducted with the CEO, all senior management staff, Human Resources Manager, staff representatives, and client service managers. Team interviews were held with community case managers, and also with case managers working in hospital settings and the central intake team.

Documentation reviewed included the HWCCAC *Administrative Policy and Procedure Manual, Community and Client Services Manual*, organizational redesign documents, job descriptions as well as minutes of meetings of senior management and middle management teams.

HWCCAC Management Structure

In the three-year history of the HWCCAC, there has been considerable change in the senior management team. Since October 1997, the HWCCAC has had a total of three Chief Executive Officers plus one acting CEO, five directors responsible for case management and client services, two directors responsible for quality management and two directors of corporate services (including finance). This amount of change in the senior management of the agency has contributed to destabilization of the organization. Of particular concern is the number of individuals who have held the position of director with responsibility for case management and client services. The area of case management and client services includes the core CCAC functions of providing access to services and resource management.

At the time of the review the senior management team consisted of the CEO, and four directors. The four director positions within the current structure include the Director of Service Coordination, the Director of Community Relations, the Director of Quality and the Director of Corporate Services.

Only one member of the current senior management team, including the CEO, had been with the HWCCAC for more than two years. Three members of the senior management team have been with the HWCCAC less than ten months and two of these less than four months. Three senior managers come to their current positions with no previous direct CCAC or home care experience. The CEO is also relatively new to the CCAC business. For about a year prior to taking on the responsibilities of CEO in January of 2000, she was Director of Case Management and Client Services.

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Middle management staffing has seen less change within the history of the HWCCAC. Where there have been new managers hired during this period, they have often been selected from within the agency. There are 16 middle managers within the new organizational model.

Organizational Structure

As of February 2001, there were a total of 194 FTE positions within the structure of the agency. Of the 194 FTE positions, 21 are management staff and 173 positions are support and client service staff. The budgeted average ratio of non-management to management staff is currently 8.3 to1 (7 to 1 actual). This ratio reflects a relatively high number of managers when compared to the history of these types of organizations. Nevertheless, staff at the front line reported difficulties in gaining access to managers' time. A contributing factor is that some of the managers and directors have little or no staff reporting to them leaving a greater supervisory workload for the other managers.

A summary of agency staffing is provided in the following table.

Hamilton-Wentworth CCAC Staff Complement

Positions	Budgeted	Vacancies	Actual	Relief
CEO	1		1	
Directors	4		4	
Managers	15.5		15.5	0.05
Case Managers	97.61	5.1	77.6	14.91
Placement Coordinators	7.98		6.5	1.48
CMA	40.84	4	35	1.84
Support Staff	26.88	1.91	24	0.97
Total	**193.86**	**11.01**	**163.6**	**19.25**

Staff Retention

In the 18 month period between April 1, 1999 and September 30, 2000, the HWCCAC experienced a loss of 23 employees. These employees were 18 case managers, 2 directors, 1 CEO, 1 support staff and 1 manager. (27 therapists also left the agency as a result of the provincial divestment policy for therapy staff.) Excluding the therapists, this represents agency staff losses of approximately 12%. The turnover of case managers within the 18-month period represents 19% of the total budgeted compliment of case managers.

A further 26 employees resigned from the HWCCAC either during or following the strike action taken by OPSEU unionized staff in the fall of 2000. These employees represent a total of 24.5 FTE positions: 9 case manager FTE, 10 relief case manager FTE, 3.5 support staff FTE, 1 case manager assistant FTE, and 1 placement coordinator.

Thus, since April 1999, the HWCCAC has experienced a total loss of 49 non-therapy employees, representing approximately 25% of the workforce. Of these 49 staff, 38 came

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from the area of case management, as case managers (27), relief case managers (10), and case manager assistant (1). This amount of staff turnover will have significant impact on any organization. Pressures created by high staff turnover include increased workload on remaining staff, low morale upon seeing co-workers leave the agency, lost productivity and expertise, the cost of recruitment of new staff and the cost and time involved in the orientation, training and monitoring of new employees.

High rates of staff turnover are also frequently symptomatic of organizational dysfunction.

The team of middle managers has not experienced the amount of turnover that has been experienced by both senior management and the case management areas. Where positions have become available, agency staff have been given the opportunity for advancement. The current middle management team was found to represent a considerable amount of clinical knowledge, as well as knowledge of the case management role and other service functions of the HWCCAC.

Management Processes

The experiences of the past six months (VON strike, HWCCAC strike, organizational change) have helped the senior management team to form a cohesive group. As a result of the relative newness of the team, the varied working conditions since October 2000, and the initiation of organizational changes, the current team has not experienced what can be considered routine day-to-day operations. As a result, it is difficult to fully assess the management processes of the full senior management team.

Minutes of senior management meetings held prior to the strike period identify regular well-attended meetings. At the meetings, senior managers received reports from the various departments, and shared new information from within the organization and from the community. Reports concerning budget and service delivery status were specifically noted, but detailed analysis of the information was not always evident. It was apparent that management struggled with the reliability of the information presented. However, it was not evident within the minutes that alternative information sources were considered to provide information for monitoring service utilization, or that effective corrective action was identified.

When case management staff were asked to comment on the accessibility of managers and the frequency of team meetings, they indicated that access to management staff has been sporadic in the past and that team meetings, although scheduled to occur regularly, did not always take place. The frequency of team meetings was noted to vary between teams and was noted to be more regular for specialty teams. Staff indicated that team managers were not always accessible when required to discuss service issues and that requests for information or questions often went unanswered. The inconsistency of access to managers was identified by staff to have significantly influenced the amount of direction provided, contributing to the inconsistency in practice among case managers and teams. Middle management staff identified that they were also concerned with the amount of time that they were available to support their staff.

Administrative Policy and Procedure Manual

The HWCCAC has an agency-wide administrative policy and procedure manual as well as various service and department specific policy and procedure manuals that are intended to support agency operations. The current administrative policy and procedure manual dated March 2000 is the result of work completed by an external consultant to update the policy and procedures of the agency. This is the first CCAC specific administrative manual for the organization. Previous administrative and operational manuals were adopted from the home care and placement coordination functions of the Hamilton VON.

The March 2000 administrative manual is presented in a logical, well laid out fashion. The contents of the manual accurately represent all elements expected in an agency of the size and complexity of the CCAC. Although the contents are presented in a user-friendly fashion and are comprehensive, the contents are not all reflected in current practice.

Not all elements have been presented to staff, nor have staff received orientation to all sections of the manual. The entire Human Resources section of the manual has not been presented to staff or put into effect. Areas where practice is inconsistent with the manual include performance appraisals and job descriptions.

The reviewers were advised that the Administrative Manual was developed to be a representation of practices the organization wished to embrace rather than reflective of current daily practice.

Administrative policies and procedures are intended to be accessible to staff on the agency's intranet system. Staff verified that this was to be the method of accessing the documents and updates but that there was variability among staff as to their individual ability to access the information.

Management of Client Services

The business of CCACs is: providing access to long-term care (LTC) services, including placement in LTC facilities, and professional, homemaking and personal support services for people at home, and the management of the related resources. Case management is a large and critical component of this business. Accordingly, the CCAC must have clear and consistent directions for case managers.

Senior management and the Board of Directors have not clearly demonstrated a full appreciation for the role of case management and the importance of a stringent case management system to effectively manage the delivery of client services within approved funding. The newly hired director for this area of services recognized that there should be some means of controlling service utilization, but understood that this function was not among his responsibilities. The title given to this director, Director of Service Coordination, does not reflect the full role or importance of case management.

As identified earlier in the report, effective case management practices are required to ensure that the right services are provided to the right clients, that service levels are

adjusted according to client needs, and that service utilization is managed within sustainable levels. However, materials submitted to the ministry from senior management (February 7, 2001) and the Board of Directors (February 22, 2001) support the conclusion that there is not an appropriate understanding of the role and importance of case management. Neither document, nor interviews with senior management, identified enhanced case management, including increased client reassessments, as a priority in order to manage service delivery.

As mentioned in the Program section of this report, direction for case management staff was found to be weak. The inaccuracies and inconsistencies, in applying provincial policy on client eligibility and homemaking services, were found to be related to the direction received by the case managers.

The review of client services management practices within the HWCCAC indicates that the problems with directions for case managers have existed throughout the two-year period covered in this review.

Human Resources

Policies and Procedures

The HWCCAC's *Administrative Policies and Procedures Manual* includes human resources policies relating to both union and non-union staff. The HWCCAC's Senior Management Committee approved these policies in February 2000. However, we were advised that most of these policies have not yet been communicated to the staff members.

Job Descriptions

There was no regular process in place for ensuring the accuracy and adequacy of job descriptions of both union and non-union staff members as outlined in the administrative manual. The area of job descriptions appeared to have been neglected. As mentioned earlier, the job description is the means of setting expectations for staff, and it is therefore important to accountability.

The human resource section of the manual identifies the requirement for all job descriptions to conform to standardized format and content. Only three descriptions for positions hired in the past six months conform to the identified agency standard.

Other job descriptions are seriously out of date, some as far back as 1988. Not all descriptions include qualifications for the position, current position titles or clear overview of duties. Some positions were represented by job postings rather than actual job descriptions.

Performance Appraisals

Although the manual identifies the need for regular annual performance appraisals, many of the staff interviewed indicated that performance appraisals do not occur on a regular

basis and that in some cases, they have not had a performance appraisal since being employed with the CCAC. Performance appraisals for management staff seemed to occur more regularly, as this is a condition for the approval of salary increases. Management staff are therefore motivated to see that their own performance appraisals occur in a timely fashion; however, appraisals for seven management staff remained outstanding at the time of review.

Lack of an effective performance evaluation process indicates a missed opportunity for recognizing good work and helping the staff develop, as well as for dealing with performance issues. It also indicates a failure of a monitoring process, and a missed opportunity to correct performance and set future expectations for staff. The process can also be used to enter into performance contracts with staff.

The Human Resource Department has identified, in its workplan, a target date of June 2001 for orientation of staff to the human resource component of the administrative manual and for the start of implementation. Performance appraisal practice is planned for implementation by September 2001, and all job descriptions are to be reviewed and updated by September 2001.

Planning for the implementation of the administrative manual is commendable; however, the lack of full implementation of the manual is of concern. The relatively long delay in implementation presents the opportunity for confusion, misinterpretation and inconsistency. In addition, the absence of clear understanding and implementation of the policies and procedures presents a potential risk to the agency.

The manual does not yet reflect the newly implemented organizational design, adding additional potential for misinterpretation.

Mutual Trust and Staff Morale

An atmosphere of mutual trust between people is essential for effective performance toward the achievement of the organization's goals and objectives. Mutual trust supports the flow of information that people need in order to make effective decisions and take appropriate action. It also supports the cooperation and delegation that are required for the smooth and efficient operation of an organization.

Open communication both creates and depends on trust within the organization. A high level of trust encourages people to ensure that everything of importance is known at appropriate levels to deal with difficult financial and operational problems. Sharing information also strengthens management by reducing the dependence on one person's or a group's continued judgement and ability.

Specific issues identified indicate that mutual trust and staff morale require immediate management attention.

- A staff survey conducted in February/March 2000 manifested a clear sense of helplessness, tension, lack of trust and poor morale among the staff. In a

summary of the findings given to the board, the CEO cited inflexibility and inadequate skills among managers. There was no evidence of improvement in trust or communication among front-line staff ten months later, in spite of a complete change of managers at the director level. Although the strike in the fall aggravated the situation, the problems preceding the strike suggest that there are much more deeply rooted issues.

- Some staff felt their performance was frequently criticized, but that there was little direction about expected performance.
- Case managers felt that their role was not valued or understood by senior management.
- Case managers felt undermined when their decisions were reversed by management without apparent justification.
- There was a climate of fear among case managers because of what they saw as past retaliation against people who spoke out.

Training

The review identified an extensive need for training staff, management and board members in the fundamentals of the CCAC business. For the first nine months of the 2000/20001 fiscal year, $70,684 is reported as the expenditure on staff and board training. With 164 actual employees, including clerical staff, and 12 board members, this amounts to an average expenditure of more than $400 per person for a nine-month period. This is a relatively high average per person expenditure without apparent improvement in the areas where training is needed most.

Recommendations

Senior Management

46. Have an external consultant assess the skill mix of the senior management team to ensure it can turn this organization around.

47. Gain external expertise to help fill the experience gap of senior managers.

Case Management

48. Reassess all active cases for eligibility and service needs, and ensure that unnecessary services are not being provided.

49. Develop and implement processes to effectively review client eligibility determination, recording in client files, service planning and authorization as per the regulations, service prioritisation, reassessments, etc.

50. Develop consistent processes to monitor and improve the CCAC's case management functions.

Orientation and Training

51. Ensure that all provincial policies and procedures are accessible to staff and that appropriate orientation, training and implementation occurs as soon as possible.

52. Team managers should meet regularly with case management staff, and use the meetings constructively to improve case management practices.

53. Ensure that all future communication plans within the agency contain a quality management component to assess and correct the accuracy and consistency of interpretation and implementation.

54. Direct training expenditures toward the basic CCAC needs identified through this review.

Human Resources

55. Ensure that all human resources policies have been communicated and understood by the staff members at all levels.

56. Provide all staff with training on how to access agency policy and procedures on the HWCCAC intranet site.

57. Create current and accurate job descriptions for all staff. Ensure that job descriptions are reviewed annually. Their contents should be tied to the organization's operational objectives and should be linked to the performance appraisal process.

58. Conduct annual performance appraisals for all permanent employees. This process should be used as part of the management approach to foster mutual trust and a positive work environment.

59. Conduct a workload distribution review for managers with the objective of distributing responsibilities and supervisory work more evenly.

60. Conduct a time management study for line managers to identify reasons for inaccessibility to front line staff. Requirements for managers to spend unproductive time in non-supervisory activities should be identified and reduced.

61. Develop and implement a well-coordinated action plan to improve the level of trust, staff morale and communication within the CCAC.

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FINANCIAL REVIEW

In conducting this review, the review team concentrated on current fiscal year 2000/01 data and used information from the preceding fiscal years where deemed necessary. The scope included a general review and assessment of the CCAC's available financial and other information, together with a review of its operating and reporting practices as considered necessary. The review also included discussions and interviews with relevant CCAC staff.

In addition, documents and analyses prepared by the ministry were reviewed and ministry staff was interviewed.

Overall Context

New funding for CCACs is based on a provincial equity funding formula. The funding approach was introduced in 1995/96 to promote equitable funding across the province. The formula is based on the age and sex of the population, provincial home care utilization by age cohort, and in addition to several other factors. It has been reviewed and adjusted in collaboration with the provincial association of CCACs and is currently undergoing a further collaborative review to see if additional factors can and should be included.

According to ministry records, the HWCCAC has received a total of $8,079,971 (17.9% increase) in new base funding since its inception on October 1, 1997.

Hamilton Wentworth CCAC Funding
($million)

	1998/99	1999/00	2000/01	% Inc
Base Funding	$45.3	$45.3	$49.8	
Base Increase		$4.4	$3.6	
Total Base Funding	**$45.3**	**$49.7**	**$53.4**	**17.9%**
One-time	$1.2	$0.4	$5.0	
Total Funding	**$46.5**	**$50.1**	**$58.4**	

In addition to a $3.6 million increase in base funding, in order to ensure there is no deficit, the ministry has provided an additional $5.0 million in one-time funding, for a total of 17.5% for this fiscal year.

The following information was provided by the ministry:

1999-2000

The December 1999 monthly report submitted by the HWCCAC indicated a projected surplus of $12,000 for the fiscal year ending March 31, 2000.

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- In January, the CEO of the HWCCAC wrote to the ministry requesting one-time funding for the renovation of additional space. The ministry's response was to proceed as long as there was no year-end deficit.
- In February 2000, the Chair of the Board requested further one-time funding. The ministry supported the expenditure provided that the board ensured it would not run a year-end deficit.
- The audited HWCCAC year-end statement indicated a deficit of $615,442.
- In a September 2000 meeting with senior staff, additional expenditures of $242,000 relating to 1999/2000 were identified. The inclusion of these expenditures would increase the "final" year-end deficit for fiscal year 1999/2000 to approximately $858,000.
- The board indicated that a poor financial system was largely the cause of its inability to forecast its financial position.

Setting Expectations

Expectations for operating within approved budgets are set out in provincial policy and legislation, as described in the General Methodology section of this report and in service agreements (which include budgets) between the ministry and CCACs.

In discussions with the review team, the HWCCAC raised the issue that ministry messages about expectations with regard to the deficit were not clear. Ministry staff provided the following summary of their communications to the HWCCAC regarding ministry expectations:

2000-2001

- On March 23, 2000, the HWCCAC submitted to the ministry a deficit budget requesting an increase of $6,745,015 million. The ministry did not accept this deficit budget and various budget scenarios were developed by the HWCCAC and discussed with the ministry.
- In the meantime, the monthly reports for April, May, June, July and August 2000 indicated a projected deficit for 2000/2001 of between $8 M and $9 M.
- These mounting deficits resulted in a letter from the ministry, on August 14, 2000, to the HWCCAC that articulated the ministry's serious concerns about the projected deficit. In its communication to the HWCCAC, the ministry noted it "*will not be in a position to approve the HWCCAC's 2000/01 base budget submission.*"
- On September 12, the Minster approved an additional $3.5 M in funding to the CCAC.
- On September 14th, in a meeting with the HWCCAC's Board Chair, Treasurer, a board member, CEO, and the Director of Finance and Corporate services, the HWCCAC presented under-funding of the CCAC as the root cause of the problem. The CCAC used selected demographic indicators to point out it serves a unique community. At this meeting, the ministry did not accept the rationale for the large deficit and stated that an operational review would be required.

- With the VON strike underway, the ministry was asked for its interpretation of the additional funding available to CCACs. In a letter to the HWCCAC on September 18th, the ministry included in its response the comment *"It is the ministry's position that you do what has to be done to maintain service levels."* This comment was in the context of the strike and the VON request for additional funds from the HWCCAC.
- The HWCCAC asked ministry representatives to meet with the HWCCAC's Finance and Audit Committee. The ministry accepted this invitation and encouraged the CEO to invite all board members to this meeting. Several board members attended. The ministry made a brief presentation indicating that its analysis pointed to the large growth in volumes of homemaking and therapy services. The ministry stated that it could not support the large projected deficit and an operational review would be necessary.
- On October 6, 2000, in a letter from the Board Treasurer to the ministry, the HWCCAC noted that the board had directed management to develop a deficit reduction plan that would bring the organization in line with the expected funding to be available April 1, 2001. A plan was to be submitted after the HWCCAC staff strike.
- In November, the ministry's Regional Director asked HWCCAC for a recovery plan.

In summary, the preceding communications would seem to support the ministry perception that, as the deficit began to emerge, there had been considerable notification that a deficit could not be supported.

The board's expectations for staff appear to be at variance with ministry expectations. For example, in the record of the Board Executive Meeting dated August 11, 2000, there is the statement: *"In reviewing our Mission, Vision and Values statements, our fiscal responsibility is secondary to our service responsibility."* Consistent with this value statement, the board did not accept a proposed strategy (as per In-Camera Board of Directors Meeting, dated September 7, 2000) to reduce the overall deficit by putting *"in place a system to cap and/or reduce expenditure for homemaking and personal support."*

Congruence of the ministry's expectations with those of the board is important to accountability. The stated mission and commitment of the board that *"fiscal responsibility is secondary to our service responsibility"* is contrary to these expectations.

In the context of clear expectations, the HWCCAC director responsible for finance expressed concern about the lack of an approved budget for the 2000/2001 fiscal year.

Recommendations

62. The lack of congruence in ministry versus HWCCAC board expectations for fiscal and service responsibility needs to be addressed by the board and/or the ministry.

63. The CCAC and the ministry should work closely together to come to agreement on an approved budget as early as possible in a fiscal year.

64. The ministry should consider providing a regular mechanism to ensure new senior management staff in CCACs have the opportunity for orientation to ministry policy, budget approval processes, reporting requirements, etc.

Monitoring

The business of providing home care services presents a major risk due to the open-ended nature of the services. Basically, there are three points where service utilization can be controlled: admission of clients, ordering of services, and controlling the length of stay. It is an expectation, therefore, that a CCAC has mechanisms in place to monitor and manage utilization of resources at each of these points.

Monitoring Purchased Client Services

The overall monitoring process in place has been ineffective in determining utilization of resources and providing assurance that the services being provided are within the resources allocated.

While the limitations of the information system (CASIS) have contributed to poor accessibility to accurate and reliable data, there was no evidence to suggest that the HWCCAC management used supplementary indicators in a meaningful manner to forecast, monitor, or correct the deficit. For example:

- There is no evidence to suggest that the management or the board used early monitoring of other indicators, such as numbers of admissions and discharges, ratios of admissions to caseload, nursing, homemaking and therapy services ordered and cancelled, growth factors, etc.

- The HWCCAC has historically used reconciled billings by service providers in the previous months to monitor and forecast costs, rather than using services actually ordered. This understated the purchased client services expensed in the previous months and only identified cost problems long after cost commitments had been made. In March 2000, the re-submissions of rejected bills and new submissions of bills resulted in the discovery of a significant, unexpected deficit for the fiscal year 1999/2000.

It appeared that there was a collective lack of awareness that the forecasting methodology applied was providing an inaccurate financial position, and there was a lack of understanding of how to monitor costs effectively.

Recommendations

65. Financial staff of the HWCCAC should assist the CEO and Director of Service Co-ordination to implement recommendations, contained in the case management section of this report, about the early collection and monitoring of the most important of the

service utilization data. This will enable corrections to be made early and as close to the point of ordering as possible.

66. Financial staff should assist the senior management team to develop and use supplementary indicators to monitor the CCAC's performance in caseload management and service utilization.

Data on Services Ordered

The monitoring of service utilization costs requires capturing accurate data on the services ordered. Our discussions indicated that reliance could not be placed on the data processed and reported by CASIS relating to the services ordered. For example, an internal report indicated that the CASIS data showed services ordered to be 30% to 40% higher than the services billed for nursing visits. A combination of factors contribute to this significant overstatement of services ordered, including the following:

- Duplicate orders entered in CASIS to force acceptance of electronic bills previously rejected by the system.

- A practice of authorizing more services than needed for new clients, resulting in services actually provided being significantly less that those ordered.

- Failure to initiate changes resulting from service reassessments, discharges, etc.

HWCCAC was able to identify its data problems but was unable to implement a back-up alternative process to accurately provide the most critical of the data.

Recommendations

HWCCAC management should:

67. Identify more accurate and timely data gathering processes. The most urgent data for cost monitoring purposes are admissions, discharges, and homemaking, nursing and therapy services. It might be valuable to ask the full CCAC staff to participate in identifying practical solutions to the problem of gathering accurate data.

68. Direct case managers to authorize only the amounts of services needed by clients.

69. Review the skills and knowledge of front line staff and their managers regarding data management, and develop and implement the indicated training plan. Training should stress the importance of accurate data and ensure that staff knows how to use it for resource management.

If the HWCCAC needs outside help, inexpensive training might be obtained from other CCACs that are familiar with simple, alternative processes for gathering basic data.

Reporting Purchased Client Services

Hamilton-Wentworth CCAC
September 2000 Budget Submission

Expenditure	Fiscal Request	% of Budget
Salaries and Benefits	$11,050,163	19%
Indirect Expenses	1,373,926	2%
Medical Supplies and Equipment	3,377,157	6%
Purchased Client Services	42,420,387	73%
TOTAL	**$58,221,633**	**100%**

Purchased client services account for more than 70% of HWCCAC's annual total expenditure ($36.12 million for the year ended March 31, 2000). The accounting procedure of reporting these services based on bills, or reconciled bills, presented serious risk, as the services ordered and provided but not yet billed by major service providers are overlooked in the accounts payable or accruals calculation. In the fiscal years reviewed, this shortcoming contributed to:

- Inaccurate monthly financial statements prepared for monitoring and reporting purposes due to significant understatement of purchased service expenditures.

- Inaccurate service and financial forecasts, analyses, and reports; and failure of the process to quickly identify and report ongoing actual or projected deficits with reasonable accuracy.

Recommendations

70. It is recommended that HWCCAC explore the possibility of requiring major service providers to provide a written summary statement accompanying monthly invoices showing visits/hours of services provided but not yet billed.

71. HWCCAC should generate other internal data to calculate accruals based on services ordered and/or provided but not yet billed.

Billing Reconciliation Backlog Due to Strike

The review team was advised that since the beginning of the strike in October 2000, bills are being paid upon receipt of invoices, prior to reconciliation. Service providers have been informed in writing that HWCCAC would be reconciling the invoices paid and initiating adjustments to their payments as necessary.

At the time of our review, HWCCAC staff was in process of making adjustments for the billing period September 16th to September 30th, 2000.

Recommendation

72. Reconciliation of the backlog of invoices should be given high priority. A monthly status report should be prepared and reviewed by senior management and the Audit and Review Committee.

Reporting of Performance Indicators

Observations

- Statements of Operations, Balance Sheet and Working Capital Statements are provided to the board monthly.
- Although budgeted statistics appear on the report, variances between budget and actual do not.
- The reports do not include YTD or year-end projected figures. Growth trends and possible year-end problems are therefore obscured.

Recommendations

73. Include the following benchmarks and data as part of the statistical/performance indicator report:
    - Monthly budgeted volumes, actual volumes and variance,
    - Year-to-date budgeted volumes, actual volumes, variance, and budgeted and actual growth over the same period last year,
    - Annual budgeted volumes, year-end projected volumes, variance and budgeted and projected growth over the previous year.
74. Include a narrative section explaining significant variances in financial and performance indicators in the monthly reports to the board.

Expenditure Forecasts

A key tool in the performance monitoring and financial control functions of CCACs is the Expenditure Forecast. The ministry requires a forecast each month as part of the CCAC Monthly Report. Forecasting enables a CCAC to identify potential over-expenditures and make corrections to prevent deficits.

As purchased client services account for almost three quarters of the CCAC's total expenditures, an accurate forecast of this expenditure line is critical to providing reliable overall expenditure forecasts.

Forecasts for 1999/2000

In May of 2000, the HWCCAC discovered that the agency had incurred a deficit for the year ending March 2000. Up until this time, the CCAC had been projecting a small surplus for that year.

Purchased client services account for almost three-quarters of the HWCCAC's total expenditures. An accurate forecast of this expenditure line is critical to providing reliable overall financial surplus or deficit projections.

In 1999/2000, the accounting procedure required that the reporting of purchased client services be based on reconciled bills rather than services ordered. This procedure contributed to:

- Inaccurate monthly financial statements due to significant understatement of purchased service expenditures.

- Inaccurate service and financial forecasts that failed to identify and report projected deficits with reasonable accuracy.

In addition, there was a failure of the HWCCAC to recognize that the CCAC traditionally showed an increase in volumes reported at year-end in March.

The HWCCAC has now changed its practice of recording purchased services when billings were reconciled. Volume statistics are now recorded when the service provider bills the HWCCAC. In addition, the HWCCAC has instituted a policy that the providers must bill all services within two months. However, the CCAC remains vulnerable to unexpected fluctuations within this two-month window, depending upon the amount of delay in billing for services rendered.

A second factor also contributed to the poor forecasting in 1999/2000. The projected expenditures and volumes for homemaking were not updated in the December, January or February 2000 forecasts despite continuing growth. In fact, February 2000 YTD homemaking volumes of 846,038 hours actually exceeded the projected annual volume of 829,577 hours with still a month to go before year-end.

Forecasts for 2000/2001

The review team also examined the August 2000 and November 2000 forecasts and the methodology used to develop the November 2000 forecast. All relevant working papers were examined and a further interview with the Director of Finance was conducted in order to understand the calculations used in developing the November 2000 forecast.

In the area of salaries, the November forecast was based on the actual expenditures from April to October, an estimated expenditure for November (the general ledger accounts were not yet closed for November) and a projection for December to March. The projected amounts were actually based on staffing levels in early September, except for a

pay equity adjustment added to the March 2001 projection. Benefits were projected based on the YTD average percentage of total salaries.

Other expenditures, including those for purchased client services, were similarly based on actual expenditures April to October, estimated November costs, and the projected December to March costs. For purchased client services, specifically homemaking and nursing, expenditures were projected based on the average year-to-date units of service from April to August. The average service level was flat lined to the end of the fiscal year, even though both homemaking and nursing volumes had increased steadily since April 1998. No explanation was provided in the working papers to indicate why the forecast suddenly provides for a flat service volume. As indicated above, the monthly projected service volumes were developed in September, based on August 2000 data. In fact, except for the period of the VON strike in September/October, service levels continued to rise. Homemaking hours for November were about 5% higher than the projected September to March levels. The November forecast did not reflect any adjustment to the December to March projections for homemaking or nursing expenditures based on these continuing service increase trends.

Recommendations

75. Ensure that bills have been received from all service agencies at the end of each month and make an estimated accrual for those that are missing or determined to be below expected levels.

76. Generate other internal data to calculate accruals based on services ordered and/or provided but not yet billed.

77. Move to a system of accruing service volumes and dollars based on services actually ordered as soon as possible.

78. Update year-end projections for <u>every</u> monthly report.

79. Clearly state assumptions relating to volumes and the corresponding dollars for all forecasts. The rationale for the major assumptions should be included. The CEO should review and understand the information in the reports.

80. Base estimates of projected volumes on a combination of historical trends and current information regarding demand and recent CCAC policy directives.

81. The monthly, quarterly and annual reports sent to the ministry should be reviewed and understood by the Audit and Resource Committee and included in the reports to the board.

Budget Preparation

Observations

- The CCAC has clearly defined administrative procedures covering the requirements and timelines of the budget process.

- Staffing budgets, working papers, background documents, etc., were professionally done and complete.

- Various "scenarios" based on different assumptions were prepared and presented to the board. These "scenarios" included an analysis of benefits, risks and potential management strategies that could be adopted in order to operate within that budget.

- After consideration of a number of "scenarios," the HWCCAC prepared and approved a "working" budget for use within the HWCCAC as the planning and control document for the 1999/2000 fiscal year. The chosen scenario included reasonable increased revenue assumptions of $3.7 M (actual $3.4 M).

- Homemaking volumes were based on a straight-line extrapolation of February actual volumes but represented a 15% increase over the previous year's budget. No provision was made for the continuing growth in volumes, and there were no strategies for containing it.

- The board specifically stated *"do not extend wait list time frames in Personal Support & Homemaking significantly."* This had been included as one of the strategies to manage the volume growth that would be required under this scenario.

- There is no evidence that any actions were taken to monitor, slow or limit the growth in service volumes although the document to the board stated *"this budget would still require changes in practice in order to continue to meet new needs."*

Service Plan Preparation

- The 1999/2000 narrative portion of the service plan was prepared separately from the financial and statistical information.

- Although the service plan provided an accurate overview of the HWCCAC operations and includes significant and accurate statistical information, it was not reflected in the budget.

- The plan referred to the implementation and review of financial benchmarks but there was no evidence of benchmarks being set or reviewed.

- The HWCCAC indicated that there has been a change in process for 2000/2001 and the written portion and financial/statistical budget will now be prepared together.

Budget Submissions to the Ministry (Base, Enhanced, Expanded and Revised)

- The base budget as submitted to the ministry was not based on any reasonable plan of action to provide services within the funding available.
  - It included a 12% decrease in building occupancy costs despite having just entered into a new lease agreement with increased costs.
  - Homemaking volumes were projected to decrease almost 10% from the previous year's budget despite evidence that volumes were up 10%, and the absence of effective strategies to contain the growth in homemaking.
- Significant difficulties in forecasting and/or controlling volumes is evident:

	Homemaking		Nursing		Therapies	
	#	%	#	%	#	%
Previous yrs. Actual	944,541		436,139		78,648	
Original Budget - (Base+Enhanced+Expansion)	1,016,430	7.6%	440,882	1.1%	87,484	11.2%
Revised Budget - submitted September 2000	1,071,977	13.5%	462,101	6.0%	89,640	14.0%
2nd Quarter Forecast - based on Nov. actuals – 05/02/01	1,106,725	17.2%	441,646	1.3%	96,803	23.1%

Recommendations

82. CCAC budgets should be developed to fit within the funding available. Until the ministry provides information about increased funding, the previous year's funding is the applicable amount. The expansion and/or enhancement sections of the budget should be used to outline how increased funding will be used when it is available.

83. The financial, statistical and written portions of the service plan should be prepared together, as is planned for the coming year.

84. Budgets should clearly state assumptions related to service volumes and the corresponding dollars requested. Rationale for the major assumptions should be included. Normally these would be based on a combination of historical trends and current information regarding demand and CCAC policies and practice. Rationale for changes in trends should be clearly stated.

85. Changes to practice that are required in order to operate within the budget should be explicitly stated, promptly implemented and carefully monitored by the board and administration.

86. Financial benchmarks and descriptions as to how and when they will be monitored, should be clearly delineated.

87. The HWCCAC service plan, including narrative, financial and statistical components should be presented to, and approved by, the board and included in board minutes.

Medical Equipment Rentals

Medical equipment and supplies account for several million dollars in HWCCAC expenditures. Our review indicated a need for some improvements to ensure more cost-effective use of resources when renting medical equipment for clients. For example:

- No policy or procedure is in place requiring the case management staff to explore cost-effective options when initially ordering medical equipment. This practice is particularly important in cases where high cost items are needed and monthly rental costs could exceed the purchase price.

- There is no documented policy requiring the case management staff to monitor and initiate corrective action when, in cases where clients are receiving services for a longer period than expected, monthly rental costs equal or exceed the purchase price. We were advised that the staff check and terminate monthly rentals where applicable.

- The present HWCCAC medical equipment policy states that the case manager can only approve two pieces of equipment for a client for a minimum period of two months. We understand the minimum two-month period will be reduced when the present contract expires.

Under the *Health Insurance Act,* it is stated that equipment is to be provided to clients. Common practice, since the Management Support Initiative, is to provide whatever equipment is required that is related to the service plan. The duration of the provision of equipment is typically limited to a three month maximum. Limiting the number of pieces of equipment is not consistent with policy.

Management staff were considering ways in which better cost-effectiveness could be achieved, including:

- seeking alternative funding sources for clients at the outset,
- requiring the vendors to award a rebate to the HWCCAC in cases where a client buys the equipment after the end of a pre-established rental period.

As noted under the section on case management, at the time of the review case managers were provided with a new policy under which case managers were not required to authorize medical equipment before it was ordered. This is contrary to provincial policy, and fails to meet the HWCCAC's resource management and accountability requirements.

Recommendation

88. Review internal equipment rental policy and procedures, implement measures that are as cost-effective as possible, and update documented policy and procedures to be consistent with provincial policy and best practices.

Medical Supplies

The contracted supplier of medical supplies currently owns and manages a system to record HWCCAC purchases of medical supplies.

- HWCCAC presently shares this vendor-managed database to conduct limited testing with the source documents to identify any major discrepancies or irregularities.

- Our discussion indicated that HWCCAC pays a delivery charge of $12 for medical supplies delivered to clients' homes, if applicable. Instances may arise where cost of supplies is less that the delivery charge of $12.

Recommendation

89. Review internal policy and procedures relating to the purchase of medical supplies to provide reasonable assurance that:

    - Amounts billed by the vendor are based on the purchases authorized by the HWCCAC and prices charged are in accordance with the contracted prices.

    - Measures are in place to avoid unnecessary or excessive delivery charges and encourage pick-up of medical supplies, where appropriate.

Asset Control

As a part of control over assets, HWCCAC maintains an asset register. We were advised that the register is being updated on an ongoing basis. However, we noted that:

- The asset register has not been reconciled to the physical inventory of its assets since the inception of HWCCAC in 1997.

- The assets are not being tagged to identify the assets purchased and disposed of.

Recommendation

90. Develop and implement policy and procedures requiring:

- Reconciliation of the asset register to the physical inventory of assets on a periodic (preferably annual) basis.

- Each asset over a predetermined cost limit to be tagged.

Payroll Processing

Prior to June 2000, an external firm was hired for processing HWCCAC's bi-weekly payroll. In June 2000, HWCCAC management implemented an in-house software package for processing payroll.

- HWCCAC staff are currently in the process of refining a monthly report ("Labour Distribution Report") which provides comprehensive FTE information. Discussion with the staff indicated that this report can be enhanced by linking FTE data to dollar amounts on a monthly basis. Such a report has a potential for use in monitoring and planning staffing requirements.

- Based on travel claims submitted and reimbursed, the current system accumulates mileage and dollar amounts claimed by each employee for travelling. Such data can be formatted to provide monthly mileage reports (showing cumulative mileage and dollar amounts) by each department or by other pre-determined criteria for monitoring and planning purposes.

Recommendation

91. Enhance the payroll reports for further use in monitoring and planning.

Administrative Costs

- A performance bonus of $5,000 was paid to a management employee in the fiscal year 1999/2000. While the board approved this expense, there is no formal policy on this issue. It should also be noted that bonuses to staff members are non-admissible expenses for CCACs (Section 4-page # 56, *Planning, Funding & Accountability Manual*).

- There is no policy in the HWCCAC *Administrative Policy and Procedure Manual* on the approval of expense claims submitted by the CEO. Expense claims submitted by the CEO were approved and counter-signed by the Director, Corporate Services, who is the CEO's subordinate.

- There is no policy on the approval of expense claims submitted by the board members. Expense claims submitted by the board members were approved by the CEO, who is the board's subordinate.

Recommendations

92. HWCCAC Board should review HWCCAC's internal policy and procedures and revise them to ensure appropriate assignments of responsibility and accountability and to cover gaps in the current manual.

93. Ensure appropriate written approval from the ministry for any expenditures requiring such approval. (eg. bonuses or one-time expenditures).

94. The Board should implement a policy requiring CEO expense claims to be authorized by the Board Chair and the Board Chair's expense claims should be authorized by the Vice-Chair.

Consulting, Training and Publicity Expenses

A brief review of certain expenses as recorded in the general ledger showed an upward trend in comparison to the fiscal years 1997/98 and 1998/99.

Description	*1997/98*	*1998/99*	*1999/00*	*Period Ending December 31, 2000*
Consulting Fees	$34,284	$29,020	$71,952	$14,635
Staff and Board Training	$16,649	$38,973	$56,995	$70,684 (includes consulting fees of about $29,053)
Publicity and Advertisement	$ 6865	$13,592	$84,429	$26,315
TOTAL	$57,798	$81,585	$213,376	$111,634

It was noted that:

- For the fiscal year1999/2000, $144,240 was paid to one vendor. The amount paid related to consulting, advertising, producing brochures, annual reports, pocket folders/inserts, etc. There was no evidence to show that written competitive quotes were obtained prior to selection of the vendor.

- As the above amount represented one-time/non-recurring expenses, the ministry's prior approval was necessary (Section 4-page # 54, *Planning, Funding & Accountability Manual*). There was no evidence to indicate that the ministry's prior approval was obtained.

Recommendation

95. HWCCAC management and board should:

- Ensure that expenditures are in line with specific funding approvals,

- Record all the consulting costs under proper accounting codes to ensure an accurate basis for comparison and reporting.

Request For Proposals (RFP) Process

Observations:

- There are clear and complete policies and procedures relating to the Request for Proposals (RFP) process for establishing contracts with service providers.

- There were indications that the staff and board review prior successes and problems in the RFP process with the idea of continuing to improve the process.

- There were no problems identified with current practices. The person responsible for the RFP has in place an excellent and carefully implemented process. However, the CCAC senior manager responsible has correctly identified the need to implement a succession plan, i.e., expand the staff expertise to additional staff members.

Management Information System Limitations

HWCCAC uses a number of information management systems that are not integrated. These systems have evolved over many years in an attempt to meet the needs of a rapidly changing environment and to incorporate technological enhancements. Currently, these systems include the following:

- CASIS for managing nursing and homemaking patient, provider and billing data,
- PMI for managing a partial equipment ordering/rental process,
- CMIS for therapy case management,
- SMS for placement services,
- An old version of ACCPAC for processing and reporting financial data,
- A stand-alone payroll/HR system,
- A system owned and managed by a vendor for recording purchases of medical supplies. (HWCCAC presently shares this vendor-managed database for conducting limited testing with the source documents).

The largest system, CASIS, is the only automated tool which case managers, middle managers, finance staff and senior managers have to record, monitor and control the daily activities related to homemaking and nursing services. Approximately 6,000 units of service are provided each business day to CCAC clients for nursing and homemaking services. The system is required to record client information, approve and schedule service delivery among the various providers, reconcile billing data from providers and produce reports for front line, management and senior management staff. More than $35 million per year of homemaking and nursing services are managed by this system.

The CASIS system runs on hardware manufactured circa 1991. The operating system, while relatively stable, is old and support for this generation operating system is

questionable. The database manager (Ingress Database Management System – Release 6.4/02) is no longer supported by the manufacturer. Three CCAC sites currently use the CASIS application. While many deficiencies have been reported since the application's initial implementation, the most critical problem for HWCCAC appears to be the system's inability to deal with the volumes processed by this CCAC. The other two sites are significantly smaller in service volume. Several reports have been prepared by the CCAC documenting and detailing the CASIS system deficiencies.

Due to the large volume of data entered into the system and the amount of time required to reconcile provider billings, report production for all practical purposes has been discontinued. This results in CCAC staff not having access to information from the automated system to verify services ordered/delivered and consequently relying on the paper files. The system contains a great deal of information about client profiles, service delivery, provider and case manager performance, but because management reports from the system are not produced, it is impossible to monitor the activities using information generated by this system.

It is apparent from discussions with staff and from reviewing some information extracted from the system, that due to inefficiencies of the system itself, some data entered is being compromised in order to "make the system work." Unfortunately, this has the effect of overstating the true volume of services approved and ordered and leaves the potential for providers to provide and/or bill over the intended service level.

Recently, the CCAC has begun to extract data from the CASIS system into another format (Access) and produce a limited number of reports from the download information. Although this additional step is somewhat cumbersome, it does appear to be a viable source of some badly needed management information. However, if the data quality in the system is not reliable, the reports, no matter the source, will be of questionable value.

It should be noted that the ministry and the *Ontario Association of Community Care Access Centres* (OACCAC) are currently in the process of developing an integrated case management information system for all CCACs in Ontario. However, it is not anticipated that a new system will be ready for implementation for several years. In the meantime, HWCCAC is developing a strategy to convert the management of homemaking and nursing services to the CMIS system. In the opinion of the HWCCAC senior management, CMIS offers adequate capability to meet their current needs.

Recommendations

96. Submit a business case to the ministry in support of the conversion of CASIS to an alternative case management system for homemaking and nursing services.

97. Correct current business practices that result in inaccurate data being intentionally entered into the case management system, to provide accurate data as soon as possible.

98. Expand the practice of downloading data into an alternative format for the purpose of producing meaningful management reports until such time as an alternative system can be implemented.

COMPOSITION OF REVIEW TEAM

Lianne Carnwath, Project Manager

Ms Carnwath's first experience with home care services was as Director of the Oxford County Home Care Program, a forerunner of CCACs, in the early 1980s. In 1986, she moved to the Ministry of Health as a home care consultant. She gradually assumed increased responsibilities as Manager and Provincial Coordinator for home care services, then Area Manager, and finally Regional Director for Long-Term Care, which included CCAC services. She was also co-chair of the implementation committee responsible for establishing CCACs across the province. In these various capacities she has participated in numerous reviews of home care and CCAC agencies. She is now retired from the ministry.

Marion Jarrell, Financial Review

Ms Jarrell is Finance and Information Coordinator in the Ministry's Central South Regional office with responsibilities for CCAC financial information. She has 18 years financial management experience in hospitals, school boards, the provincial government and industry. Ms. Jarrell has an MBA degree and will obtain her CMA designation in June 2001.

Amin Jivraj, Management and Financial Review

Mr. Jivraj is a Risk and Assurance Consultant with Management Board and has done many operational reviews of agencies providing home care and other health services.

Rob Low, Management and Program Review

Mr. Low is the ministry's Program Supervisor responsible currently for the HWCCAC. He has had extensive experience in the Program Supervisor role with a wide variety of community service agencies.

Sharon Marsden, Program Review

Ms Marsden is a ministry consultant working in the area of program policy, particularly related to CCAC services. In the 1980s, she was Director of the Brant County Home Care Program, and moved to the ministry as a home care consultant in the late 1980s. She has been responsible for both operational and policy work in the course of her career with the ministry, and has done numerous reviews of home care and CCAC services.

Jim Murray, Governance Review

Dr. Murray is an independent consultant with acknowledged expertise in governance, organizational effectiveness, change management, and public accountability. He has done numerous reviews of hospitals and other private and public sector organizations, and has been a hospital board chair, university teacher, corporate CEO, author and mediator. Dr. Murray conducted the governance review.

Ray Rennie, Financial Review

Ray is an experienced member of the ministry's East Regional Office finance staff, who has had both program and finance responsibilities for CCACs and other agencies. He has participated in the reviews of a number of CCACs.

TERMS OF REFERENCE

Scope

The review of the Hamilton-Wentworth CCAC is intended to determine the capacity of the CCAC to provide identified services consistent with expected practices for CCACs, and provincial legislation and policies, and identify and investigate factors that have contributed to the current deficit position.

Objectives

- To assess the board's role and performance in the functioning of the CCAC and make recommendations for enhancing governance effectiveness.
- To assess the CCAC's financial and information management systems, controls, policies and procedures.
- To assess current case management practices, including determination of client eligibility and priority setting for service delivery and reassessment of client service needs.
- To assess compliance with the *Long-Term Care Act, 1994*, the Service Agreement, the ministry's *Planning, Funding and Accountability Manual*, and ministry policies for CCACs.
- To recommend implementation of short and long-term strategies to realize operational efficiencies.

Review Process

The review of the Hamilton-Wentworth CCAC will include but not be limited by the following activities:

- Review of CCAC Board structure, membership, meeting minutes, policies and procedures,
- Review and assess all operational policies and procedures of the CCAC,
- Review and assess HR strategies, including current CCAC structure, job descriptions, staff training and development practices,
- Review and assess current quality management practices,
- Interview selected CCAC staff, in consultation with management, to review the application of the policies and procedures related to service delivery, program and financial procedures and controls,
- Review program and financial files and appropriate documentation,
- Conduct a review of sample client files as required.

Review Team

A team will conduct the review with expertise in the areas of governance, finance and CCAC service delivery practices.

GOVERNANCE REVIEW

A Review of the Governance of the Hamilton-Wentworth Community Care Access Centre

Report to the Ministry of Health and Long-Term Care

Submitted by:
optimal solutions *international*
Guelph, Ontario
February 28, 2001

Preamble

Governance is the process of leading and directing the work and effective performance of an organization. The primary purpose of governance is to ensure the achievement of desirable outcomes for the people who are served by the enterprise. In accomplishing that end, governance must create and sustain structures and processes that ensure transparency and accountability to all of its stakeholders.

The call for board reform and revitalization, in both the private and public sectors, is not new. The rapidity and complexity of change, as well as the economic imperatives that accompany change, have simply intensified the call for action. Research tells us that the reasons why organizations fail can be seen well in advance of the crisis that imperils their function. Invariably, the governing bodies of once thriving entities are unable to understand the full import of impending threats, attendant risks and environmental impacts and thus are incapable of formulating effective responses in a timely and adequate manner. Simply put, *they do not adapt to changing circumstances, make strategic choices and deliver on their responsibilities*. In other words, they fail to provide leadership or accountability.

The Centre for Quality in Governance describes the challenge facing most boards this way:

> *"In essence, the reason why some boards are unsuccessful is because they become desensitized to the realities of the changing environment. This is sometimes the result of complacency and inertia. However, the major problem is that traditional board structures and processes were designed for times of greater simplicity, stability and less hostile conditions than pertain today. Our system of governance is obsolete and ineffective in dealing with our complex and changing world. Standards for director behaviour are lax, and the governance process as we know it is failing us just when we need it most!"*

James Orlikoff, a highly regarded expert on governance has astutely observed that *"For governance to effectively lead health care into the future, new mindsets and structural characteristics are clearly necessary."*

In seeking to contribute to "a new standard of excellence" for governing boards, the Carver Governance Design firm defined the key challenge as follows:

> *"Of all the elements in the management of the enterprise, none is less studied and less developed than the governing board. Because governance has rarely been the subject of rational design, boards persistently fall into trivia, short-term myopia, meddling in the staff work and other failings. They do so even when composed of intelligent, experienced, caring members."*

Clearly, community-based boards are not perfect. They are comprised of well-meaning volunteers whose primary interest is community service. The directors give unstintingly of their precious time and are dedicated to the task at hand. They

genuinely want to make a positive impact on the organization and on the quality of the services being rendered to the community. Unfortunately, regardless of skills or support levels, many volunteer boards in the health care sector are increasingly being overwhelmed by the speed, complexity and cost of the changes currently being made or contemplated for the future. In addition, many individual directors lack an understanding of the fundamental role, responsibilities and principles of sound governance.

While the focus of this governance review is the Board of Directors of the Hamilton Community Care Access Centre (formerly the Hamilton-Wentworth Community Care Access Centre) in the context of an exponential growth in service volumes and a resultant fiscal crisis, it is valid to note that the concerns surrounding the role, structure, performance and composition of the governing board, as initially identified by the client, are not unique to this organization. Indeed, similar challenges, questions and concerns confront most public-sector boards across the country. In a survey of 100 Canadian business leaders who served as trustees of health care organizations, the key findings included the following:

- 47% of the trustees surveyed indicate dissatisfaction with the composition of their board;
- Only half of the directors believe they receive enough information to understand and make decisions on the complex issues of governance;
- 53% feel adequately prepared to judge the quality of care provided by their organization or to make policy changes that would improve the quality of services/care delivered; and
- The most distressing aspects of board service are the slow, bureaucratic decision-making process and the need to make tough resource allocation decisions.

The value of this survey, as well as other literature on public sector governance, is that it provides a useful perspective and underscores the fact that the challenges facing the board of the Hamilton-Wentworth Community Care Access Centre (henceforth HWCCAC) are not necessarily unique. What appears to be different and significant, for this board and perhaps also other CCACs in the Province, is the manner in which the board (and thus the organization) was initially created and, hence, the philosophy of governance that ensued from an operation that began with a board but few, if any, staff.

The crux of the dilemma facing boards which must govern health care organizations today is the challenge of reconciling unlimited demands with limited resources. While the wisdom of Solomon might be helpful, this difficult challenge can be creatively managed provided several key elements are in place (such as clear and unequivocal public policy parameters, a well conceived strategic direction, the utilization of appropriate expertise and experience, a motivated and properly supported team of professionals to execute the action plan, and so on). But, above all, it requires leaders who understand their principle role and who can work together as a team with the resolve to make the tough choices and insist upon implementation, monitoring of performance standards and continuous improvement. This is the essence of sound governance and the focus of the initiative described in this report.

Scope and Method of Review

The purpose of a review is to conduct an objective assessment by an independent and unbiased observer with acknowledged expertise in the area under investigation. The focus of the enquiry is to assess "how things are done" in the context of "how they *should* be done." The process of examination is geared toward ascertaining patterns of behaviour rather than keying on isolated incidents. The objective is to identify, describe and assess (in terms of accepted standards of governance behaviour and what are known to constitute "best practices") rather than to prove unequivocally the observations and findings.

The purpose of this particular exercise was to undertake a comprehensive examination of governance and related matters that fall under the formal jurisdiction and responsibilities of the Board of HWCCAC. The client-defined deliverables included an examination of the following:

- The board's understanding of its role and responsibilities (including such matters as public accountability and the board/CEO relationship);
- The board's understanding of strategic issues currently confronting the organization and its capacity (including appropriate control mechanisms) to respond effectively;
- Director skill sets, leadership and decision-making capabilities;
- Board orientation, education and evaluation;
- The adequacy and integrity of the Corporation's membership structure and succession planning process;
- The adequacy of the current model of CCAC governance to serve the needs of its stakeholders and consumers into the future; and
- The board's understanding and ability to respond to designated issues and concerns identified by a parallel review of financial and operating protocols in support of service delivery.

The process of enquiry focused primarily on depth interviews with as many board members as were available and willing to be interviewed and who had served during the period in which the fiscal crisis occurred. Accordingly, all board members serving during 2000 were interviewed (refer Appendix A) with the exception of one (founding) director who refused to participate in the review process.

As the board/CEO relationship is a fundamental indicator of the board's understanding of governance and its performance against conventional governance expectations and standards, interviews were also conducted with the three individuals who have held that position of responsibility since the inception of the organization in 1997. Where appropriate, for the purpose of ascertaining corroboration of assertions deemed pertinent to the review, discussions were held with others who were members of senior management during the period noted. To provide the reviewer with an understanding of how CCACs function, and how similar challenges as those confronted by the HWCCAC board are handled, depth interviews were also held with an experienced CEO of a CCAC that the client deems to be functioning well and an external consultant considered knowledgeable in the purpose, history and functioning of provincial CCACs. The

reviewer requested and received a wide variety of HWCCAC documents that were determined to be helpful in satisfying the objectives of the review. In this regard, the CEO, Mary Burnett, was most cooperative.

The above noted interviews were scheduled over a period of four weeks. In addition to the corroborative discussions held with individuals who had pertinent knowledge of germane issues, as noted, the depth interviews lasted a minimum of 90 minutes to a maximum of three and a half hours. Based on prior, relevant reviews, the assessor is of the belief that the examination of the issues identified was sufficiently comprehensive to address the client's description of deliverables.

The scope of this review is consistent with the standards, principles and "best practices" of governance as evidenced in leading international and Canadian studies, such as the report of The Panel on Accountability and Governance in the Voluntary Sector (also known as the *Broadbent Report*, 1999), the report of the Toronto Stock Exchange on corporate governance (*Where Were the Directors? Guidelines for Improved Corporate Governance in Canada*, 1994), as well as industry specific models and criteria, like those developed by the Canadian Council on Health Services Accreditation (*Guidelines on Hospital Governance*, 1998) and the Ontario Public Hospitals Report (*Into the 21st Century*). A bibliography of pertinent literature on health care governance is contained in Appendix B.

The board's resistance to the governance review (as will be noted) has compromised the clarity of the findings. Many directors disagreed among themselves on the questions asked or perceived the issues differently, thus making it difficult to specify firm conclusions. Answers to some questions were changed or "clarified" hours later. Memories that were "crystal clear" on some questions became "foggy" when responding to questioning around inappropriate behaviour. While such behaviours are not unusual in reviews of this kind, the extent of the resistance (with notable exceptions) is unprecedented in the reviewer's experience. Although the "disconnects" on key issues will be noted, where there was dissensus without corroboration, findings have been discarded.

The lack of willing participation on the part of most directors appears to be a function of the board's severe mistrust of the client's motives in undertaking the review and a belief that the scope and process of the enquiry should not go beyond interviews with current board members. As will be evident (see "Outcomes"), the vast majority of directors believe that they are doing a good job and therefore view the review of governance as either unnecessary or "politically motivated."

For reader friendliness, this report uses the terms "director," "board," "corporation" and "chair" in the lower case. "Ministry" means the Ministry of Health and Long-Term Care. "Executive" refers to the Executive Committee or members of same. "Trustee" is synonymous with director. Other than the chair, whose position of responsibility is critical to sound governance, and occasionally the Treasurer when his role is central to the issues under examination, no director has been identified by name (respecting the

condition of confidentiality). To provide context and richness of meaning, most quotations cited are remarks made directly to the reviewer. It would be a mistake to endeavour to attribute specific statements to individual directors – any comments made that were deemed important to the findings but that might possibly reveal identities have been edited or disguised so as to protect the principle of confidentiality.

Findings, Observations and Analysis of Critical Issues

What Constitutes Effective Governance?

As will be noted, the HWCCAC board distinguishes between an "operational model of governance" and what it describes as "a true governance model." In order to appreciate the latter benchmark, the following briefly outlines the advice of acknowledged governance commentators, theorists and reports on what makes an effective board. Virtually all agree that *the primary focus for improved governance lies in ensuring that the role and responsibilities of directors, both individually and collectively, are clearly understood and practiced.* This is even the case for well-run boards.

In the U.S., John Carver is a high profile activist supporting new directions for public sector governance. He has outlined the following as key board activities which are central to effective governance:

- Explicitly addressing fundamental values;
- Ensuring an outcome-driven organization;
- Enabling proactivity and change adaptiveness;
- Forcing forward thinking among the board and senior management;
- Building relationships with relevant constituencies (customers, staff, neighbours, etc.); and
- Determining the information necessary to do its job (and avoiding wrong information).

In this model of governance, customers are the first priority, the board is an agent of change and decisions are based on reliable and understandable information. Carver sees these elements as necessary if the board is to "pursue excellence more than solve problems."

There are slightly different views but common themes on what constitutes an effective board. In the reviewer's opinion, a board must:

- Clearly articulate the institution's vision, mission and strategic objectives;
- Provide leadership direction and counsel for the CEO;
- Set and monitor standards that ensure quality of patient care;
- Ensure that appropriate, adequate and timely information is provided by management;
- Oversee financial planning and insist upon cost containment;
- Build linkages and communicate effectively with all key stakeholders – the community, government and other health care providers;
- Evaluate organizational performance and mission effectiveness;
- Develop its own skills and effectiveness in keeping with the changing needs of health

care generally and the hospital specifically;
- Strive for excellence based on system-wide benchmarks; and
- Be change adaptive, proactive and forward thinking.

The Panel on Accountability and Governance in the Voluntary Sector has proposed a "*A Code of Good Governance Practices*" that is also worth noting. It recommends that good governance consists of:
- Ensuring the board understands its responsibilities and avoids conflict of interest;
- Undertaking strategic planning aimed at carrying out the mission;
- Being transparent, including communicating to members, stakeholders and the public, and responding appropriately to requests for information;
- Developing appropriate structures for the organization;
- Maintaining fiscal responsibility;
- Ensuring that an effective management team is in place and providing oversight of human resources;
- Implementing outcome-based assessment and control system; and
- Planning for the succession and diversity of the board.

In December 1994, the Toronto Stock Exchange Committee on Corporate Governance produced a report which is widely acknowledged to be the standard for corporate governance and compliance in Canada (reference Appendix A). Its guidelines for effective governance begin with a definition of stewardship, as follows:

> "The board of directors of every corporation should explicitly assume responsibility for the stewardship of the corporation and, as part of the overall stewardship responsibility, should assume responsibility for the following matters:
>
> 1) adoption of a strategic planning process;
> 2) the identification of the principal risks of the corporation's business and ensuring the implementation of appropriate systems to manage these risks;
> 3) succession planning, including appointing, training and monitoring senior management;
> 4) a communications policy for the corporation; and
> 5) the integrity of the corporation's internal control and management information systems."

The Canadian Council on Health Services Accreditation recommends the following as the characteristics of effective governance:

- The board should be comprised of people with the necessary knowledge, ability and commitment to fulfil their responsibilities;
- The members should understand their purposes and those whose interests they serve;
- Members should understand the objectives and strategies of the organization they govern;
- Members should know and obtain the information they require to exercise their responsibilities;

- Members once informed should act; and
- members should discharge their own accountability obligations by reporting on their organization's performance.

The sum of the above views is illustrative of a "true governance model." While the reader must remain cognizant of the caveat that follows, this review will comment on some of the "essentials" that appear to be missing in the HWCCAC board's approach to leading the organization as well as its failure (as evidenced by inappropriate behaviours) to "operationalize" some of its own self-declared tenets of governance.

The HWCCAC Board's View of Governance

The findings of this review must be read with an understanding of how the board of HWCCAC views its governance role and responsibilities. The directors freely admit that they are "moving toward a governance model" and that, from the beginning and at the present time, they continue to function as "an operational board." What this essentially means is that the board selectively manages parts of the enterprise while "governing" others.

The board sees the progression or evolution from being "very involved in the guts of the organization" towards what it calls true governance as "more rapidly increasing during the past year or so," coincident with the tenure of its current CEO. Accordingly, during the first two years of its operation, the board was a very "hands-on" group that functioned in a command and control mode. During this initial period, the first Executive Director and the ensuing CEO were largely "told what to do." The evidence indicates that the board made virtually all important management decisions and expected the CEO to carry them out. Prior consultation was rare and subsequent opposition to the board's direction, particularly with regard to personnel matters, was summarily dismissed (often with consequences). The board genuinely believed, since it "started with a clean slate and little direction from the government," that its fundamental responsibility was "to build the organization from scratch." This included the clear intent of "creating a culture that was different from the VON days."

Those who would be considered to be the primary architects of the board's model and style of doing business from the beginning differ only slightly on the current status of progress towards a true governance model but generally concur to being "80-90% there." The sense is that the pace is appropriate and legitimate "given all that had to be done from the beginning and the changes we needed to make." One indication of this evolution is the current agenda of the board's RFP committee, which is "to determine the continued need for board involvement" (a recommendation that arose from the February 2000 board retreat which has yet to be considered). It is the reviewer's conclusion (based on several examples) that this board has a hard time "letting go" of control over practices and functions that should reside within the purview of management.

The board fundamentally believes that it is doing a good job in leading the organization. A report that does not validate this self-assessment will be viewed as confirmation that the real agenda is "to get the board" or, as several directors, suggested:

- The report is already written ... you're just here to fill in the blanks.
- You were hired to give them the answers they want.

Hence, in the appraisal that follows, the reader should be aware that the board openly acknowledges that it will continue to have an operational role and that it believes it has been doing an exceptional job in this regard.

Recommendation #1:

Other than a failure to comprehend "how to" do it, there is no reason why, after almost four years, the HWCCAC board cannot function in full compliance with the principles of a true governance model, as described. Accordingly, with external assistance if required, the board should move expeditiously to adopt such a model of governance.

Accountability

Increasingly, public sector boards are being required to address the issue of accountability. CCACs operate in the public interest and must acknowledge the needs of several stakeholders – these include those who consume its services, the community's need for an effective and efficient continuum of care, the corporate members who elect the directors, the staff who provide the services, and the government which, on behalf of the public, pays the bills.

A primary responsibility of the board is to manage risks to the organization on behalf of the above noted stakeholders. This is why the board has no option but to be fiscally responsible in addressing the health care needs of the community. *Effective governance is the ability to make strategic trade-offs while living within available resources.* It is the board's responsibility to ensure its senior management team brings forward clearly articulated options and quantifiable alternatives in the context of *both* community need and resource availability and to then decide on an appropriate plan of action for staff to execute. Failing to do so is failing to be accountable.

The ministry's view of accountability is as follows:

> Transfer payment agencies receiving funding from the Ministry of Health and Long-Term Care should provide assurance to the ministry that the designated funds are being managed prudently to meet the ministry's expectations under the ***Long Term Care Act (1994)*** and related regulations, as well as planned objectives and results. The ministry expectations are that *service needs will be met within available resources* on a fair and equitable basis.

Members of the Board of HWCCAC have indicated that they do understand their public accountability (to whom and for what). Furthermore, board orientation materials clearly spell out director responsibilities and the board's role. That being said, they have (as a board) knowingly defaulted on their responsibility as a governing body on the understanding or belief that, by following the ministry's direction to "maintain service levels," they could live beyond their means. While the directors may possess a good theoretical grasp of governance principles, they seem unwilling or unable to put them into practice – in the vernacular, they don't "walk the talk."

It is the board's contention that the ministry implicitly and explicitly, both verbally and in writing, condoned the current strategy of maintaining service levels despite an inability to fund them within approved resources. Accordingly, on the further understanding that the deficit would be addressed by the ministry at some point in the future, the board "made a conscious choice to go over budget." (The ministry has a different point of view, supported by its own documented evidence, namely that deficit budgeting has always been unacceptable and that this message was clearly, consistently and frequently communicated to the board and management of HWCCAC.)

Almost to a person, the directors are adamant that the deficit is entirely attributable to the ministry (because of either the direction given/perceived or "mixed messages" or underfunding). The scenario offered to substantiate the claim of "being led down that road (running a deficit)" is this:

> "We signaled the ministry of our worsening position but were blind-sided by further unexpected costs, escalating demands and the strikes. When we asked for direction, the ministry did not respond. All they said was 'that's the way it is.' It felt like a set-up. They made no commitments, other than 'don't cut your service levels' – that's a direct statement."

Whereas the ministry did advise HWCCAC to maintain service levels, it was (and is) the board's responsibility to decide how this would or could be done. The record indicates that the board made a conscious choice to run a deficit in favour of continuing existing service levels. While the board advises that this direction came explicitly from the ministry in a letter dated September 18/00, the board had already made this decision. The minutes of the Executive Committee meeting of August 11/00 include the following statement: "our fiscal responsibility is secondary to our service responsibility." A few directors spoke candidly of this decision: "We made a conscious decision (to run a deficit) based on our interpretation of our mission." Taking into consideration the timing of events and decisions, as described by all parties, the board appears to have conveniently decided to selectively adopt the ministry's advice, in part, as an excuse for being fiscally irresponsible.

Each director was asked to identify where the responsibility for the current fiscal predicament lies – with the board, with the CEO/management team or with the ministry? While two directors acknowledged that the responsibility must be shared, they quickly pointed to "ministry underfunding" as the root cause. (The board has also argued openly

in forums with area MPPs that the organization was underfunded.) The only director to suggest the board was responsible ("because we have a duty to be fiscally responsible") qualified his view with this explanation: "But we got mixed messages from the ministry ... don't worry about the deficit, we'll get through this."

In essence, the board absolved itself of the responsibility to balance the books:

- The ministry did not give us enough funds to do our job and provided us with no directions when we were facing a deficit.
- We haven't done a good job, but it's the environmental factors that prevented us from doing a good job.
- Our deficit, compared to others, was not totally out of line.
- The government directive to uncouple home care from nursing contributed to our deficit.
- Our biggest problem is the information system – the agency is too big for the system.
- We can't get enough staff.
- We didn't have an option on the therapists ... the ministry dictated this.
- Demand kept increasing, then the strike arrived.
- The government doesn't look at why our circumstances are different in Hamilton-Wentworth.

When pressed, even those who understand the duty to be fiscally responsible are wont to rationalize the failure to do so by reference to the mantra of underfunding. Perhaps stimulated by the advent of the operational review, the board has now begun to address its financial predicament more aggressively with a debt reduction strategy. Despite these efforts, there remain at least three directors who appear unwilling to "get the house in order."

- Right or wrong, we're going to keep going the way we've been going – continuing with our service criteria.
- The board position is that we are not going to bring our deficit back in line.
- It's not ethically right to cut services.

(See also the director responses to questions regarding financial and operational controls under "Disconnects.")

The CEO of another CCAC, whose organization has faced the same challenge of rising demand for services in the context of limited funding indicates that "there are things that can be done and choices that can be made." These choices were defined as ranging from establishing triage protocols to what were considered to be "more aggressive steps" such as creating waiting lists and keeping staff compensation under control. While finance and operations are the focus of another part of this comprehensive review, the point to be made is that some boards have clearly confronted, sought to better understand and come to grips with reconciling service delivery and funding challenges. That being said, there is also an acknowledged dilemma facing CCAC boards as most are aware that "historically, all deficits have been funded" or, as one CEO frankly admits, "we weren't

rewarded for being fiscally responsible and cutting services." Hence, there is a temptation for boards to tolerate deficits on the understanding, or the hope, that the Ministry "will bail us out." The HWCCAC board insists that it was not influenced by this "traditional practice."

Beyond its seeming unwillingness to balance service expectations with funding parameters, the board's approach to external communications (see "Stakeholder Communications"), its corporate membership (see "Corporate Membership") and the holding of open board meetings suggests a deliberate tendency towards secrecy and thus a failure to be transparent (and accountable) in the conduct of governance. The reviewer is at a loss to explain why so many directors believe their approach to conducting so much business behind closed doors is "not unusual."

The conventional wisdom on governance of public sector organizations suggests that *in camera* sessions should only be held to consider three types of business, namely those relating to personnel matters (such as staff compensation), property and legal issues. In the reviewer's opinion, the majority of business items that are discussed *in camera* could be considered during the open session of the board. *In camera* deliberations should be infrequent rather than the normal and preferred approach to conducting business. Even though several directors concede that the regularity and extent of *in camera* meetings demonstrates "not a lot of transparency," the board appears oblivious to the fact that how it has traditionally conducted its business is a primary contributor to the prevailing perception of it as being "closed."

Per the *Canada Corporations Act*, the minimum size of a properly constituted board consists of 12 members. It is the consultant's understanding that most CCAC's had 12 board members shortly after the start of operations in 1997. While 12 directors were initially appointed to the HWCCAC board, seven were removed when conflict guidelines were subsequently introduced by the government. Hence, the first board started with five directors and these five largely determined the architecture and pace of governance. The number of directors rose to ten by the end of 1998 and reached full complement in November, 1999 – over two years after the founding directors had determined the *modus operandi* of governance and established its key protocols. It is alleged by some directors that, despite an open application process, the directors added to the original group were "hand picked." Although the slowness of the board in recruiting its full number of directors is curious, the evidence supporting the allegation is inconclusive. Three of the initial five directors stepped down at the January/01 AGM.

Recommendation #2:

The HWCCAC board should seriously re-examine its understanding of and commitment to public accountability and this scrutiny must be undertaken with a view toward achieving greater transparency through (*inter alia*) improved stakeholder communications, more open board meetings and the building and nurturing of the corporate membership.

Recommendation #3:

Any director who disagrees with the fundamental governance principle of fiscal responsibility should step down from the board and be replaced through the recruitment of directors who are willing to find the balance between community needs/expectations and public funding. (See also "Board Skill Sets.")

Board Committee Structure

The board appears to review the adequacy of its committee structure from time to time. As noted, the current focus of the RFP committee is whether it needs to exist. Curiously, as will be noted, the Public Relations Committee is asking the same question. At the AGM in January, changes were made to the names of two committees (Executive was changed to Governance and Finance was changed to Audit + Resources) although the reasons, other than cosmetic, are not clear (the reason given for the change in name from an Executive Committee is that "the focus on governance is broader").

The roles, responsibilities and *modus operandi* of each of the existing board committees should be more closely reviewed as a means of enhancing board productivity. In addition to outlining the function or purpose of the committee and its membership, the "terms of reference" should ensure that adequate attention is given to the skills and resources needed to assist deliberations and accomplish the work at hand. The terms of reference should be written more as job descriptions (reviewable at annual retreats) with key result areas or deliverables noted. The greater the precision in elucidating these performance expectations, the greater will be the support given to the board. A problem/solution orientation would help streamline decision making and optimize the board's time.
It is unclear whether the Audit Committee is separate from (or a part of) the Resources Committee as the membership appears to be the same. Committees should not "mark their own homework;" accordingly the membership of these two committees should be segregated.

Similarly, combining the Executive and Governance functions in the same committee smacks of a continuation of the historical desire of the "executive group" to control all things. These two functions are critically important to properly functioning governance and therefore should be distinct (although the chair should be a member of both). Organizations that have tried to combine these functions into a single entity have invariably ended up giving insufficient attention to governance effectiveness. In addition, a Governance Committee (responsible as it is for board development, effectiveness and evaluation) has an oversight function over the Executive Committee.

The establishment of a Governance Committee is not about being "politically correct." Its purpose is the ensure accountability through the development of appropriate mechanisms and processes that enable the board to measure and monitor its performance. In addition to assessing the conduct of the board itself, this evaluation function must also include the CEO, the chair and board committees. It follows that the Governance Committee is responsible for board development and continuous improvement – for the

ongoing education of individual directors (through the development and monitoring of an orientation program that meets the needs of the organization, an awareness of relevant conferences on industry practices and trends, and the design of annual retreats that address emergent or strategic needs confronting the board). Lastly, the Governance Committee is responsible for ensuring the board's own rules of conduct, its by-laws, are consonant with changing circumstances and public policy that affect the organization.

A properly constituted and mandated Executive Committee should identify the information needs of the board and communicate same to the CEO. It should plan the board's agenda so as to optimize the time and skills of its members. It should deal with and expedite routine matters (as defined and determined by the board) to ensure the board can productively focus on the more vital, contentious or strategic issues and challenges that must be addressed. The board must not be relegated to the role of simply "rubber stamping" Executive Committee recommendations. Members of the Executive Committee who perceive themselves to be a "star chamber" for making the tough decisions only serve to alienate, undermine and erode trust within the board. The chair's role is to ascertain or determine (before and during board meetings) which issues are routine and which are deemed vital to discussion by the board as a whole.

While an Executive Committee typically meets monthly or "as required," a Governance Committee convenes quarterly (and certainly no less than semi-annually depending on the evaluations systems and board development infrastructure in place). Its job is to ask the question: *"How are we doing and could we be doing our job more effectively?"* The Executive Committee, on the other hand, must focus its attention on this question: *"What are our (the board's) priorities today and how can we best organize our time together (and our information requirements) to achieve optimal results?"*

Recommendation #4:

The board should move to establish the following standing committee structure, with appropriate job descriptions, work plans, meeting frequency and membership to ensure better utilization of resources, enhanced information management and streamlined decision making:

- Governance (to include the existing committees on Nominating and Education/Board Development)
- Executive (with role primarily as described above)
- Resources (Finances, Corporate Services and RFP approvals)
- Stakeholder Relations (expanded role, including Corporate Membership; see "Stakeholder Communications")
- Quality Assurance (Service Delivery)
- Audit

The Board/CEO Relationship

Role clarity between boards and their CEOs is achieved when directors, individually and collectively, understand and embrace the following principles of governance:

1) The board has the primary responsibility to determine and monitor the strategic direction of the hospital. The task of strategic leadership is not the prerogative of senior management.

2) While the board/CEO relationship requires flexibility based on clear principles, management must provide pertinent, timely and intelligible information (as this is defined by the board and not management) in order to ensure adequate measurement and accountability to the stakeholders.

3) A properly functioning board will focus its attention on *what* needs to be done – it will set the strategic direction and establish appropriate policies for the management team to follow. The CEO and the senior managers of the institution will be primarily concerned about *how* to implement and manage these policies, as well as with how best to report effectively on the progress of same. Both the board and the CEO must determine how best to monitor performance and, accordingly, design the performance indicators required to ensure the board can understand and effectively monitor progress (both against internal targets and in the context of system-wide comparisons).

4) The board/CEO relationship ought to be synergistic because good governance is dependent on an excellent management team.

5) The CEO is an employee of the board and serves at its pleasure relative to his/her performance against mutually determined objectives.

A strong CEO can be helpful in enhancing governance effectiveness. He or she can emulate the desired role demarcation between board and CEO. As the full-time healthcare professional in charge of the organization's performance, he or she has a responsibility that goes beyond providing the board with timely and appropriate information to enable it to deal with the issues and make decisions in an informed, intelligent and strategic manner. The CEO also has a duty to talk openly and candidly with the board about issues and problems that are of concern to staff and to defend recommendations regarding operational performance and outcomes. The CEO needs to be mindful also of a responsibility to offer a commentary/perspective on matters which the lay members of the board may find difficult to comprehend. Properly constituted, the board/CEO relationship should be a partnership with clearly defined roles and responsibilities as well as desired attributes which can energize the staff and instill confidence among stakeholders.

As previously indicated, the HWCCAC board has never treated its CEO as a "partner" – they are deemed to be employees, clear and simple. The previous CEOs were directed,

more than requested, to do the board's bidding. This, in large measure, explains the turnover of CEOs (see below). The current CEO is more widely trusted and respected by the vast majority of directors – "Mary is the best thing that's happened to this board." Some suggest that she is one reason why the pace towards achieving a true governance model has been expedited. Were she to become more challenging of the board, and the chair in particular, she would be more influential in altering this culture-bound master/servant relationship. This lack of assertiveness may be attributable to her having no prior experience as a CEO reporting to a volunteer board.

There is ample evidence to indicate that both prior CEOs were "placed in untenable positions" by the board and thus, in effect, "forced to resign." Traditional and expected CEO authority was frequently undermined and directly challenged. The printing of specific details in a report such as this would serve no purpose other than to embarrass those directors who were involved in these situations.

Designating the CEO as an "*ex officio* director" makes little or no sense. Other than a title, the position carries no voting privileges (and a director, by definition, votes) and the role is fundamentally that of a resource person, which the CEO would be in any case. Given the duties and responsibilities of the CEO, she must be a full participant in deliberations regarding policy and organizational leadership issues. However, since the CEO is also accountable to this same body, and indeed serves the board relative to clearly articulated performance measures, she cannot also act on equal terms in matters of voting. This distinction brings (and reinforces) the necessary role clarity to the board/CEO relationship.

The "power" of the CEO (to call it that) does not come from having voting privileges at the boardroom table but from knowledge, experience, preparation, openness and the support of those who work in the organization. And denying the CEO a vote at the table does help to clarify the respective roles in governance. When the board, CEO and management staff more clearly understand their respective roles in governance, there is a synergistic "pulling together" that can lead the organization to accomplish great things. Effective governance is not about checks and balances on the expression of power but about the sharing of power through role and goal clarity.

It is odd that the recording secretary for the board for an extended period of time was an employee of one of the directors and was paid a stipend for her services. (This person retains this role to this day but is no longer employed by the director who remains on the board.) While this task is normally the function of the CEO's secretary, the arrangement is consistent with the command and control orientation of the board and illustrates a pattern of mistrust of staff (note, for example, the reference to the board's voice-mail box made elsewhere) and disrespect of the CEO's normal role of providing support for the board.

The evidence supports the claim of board micro-management. But the board also confesses unapologetically to that as an intentional style of governance. Suffice it to say that, while all public sector boards tend to "meddle" to some extent if not reminded of

their proper role, this board has gone further than most. Board members have talked directly to line staff, sometimes without the knowledge or consent of the CEO. Contact has been made directly with case managers on the basis of calls received in the board voice-mail box. The board has intervened in the handling of consumer complaints and appeals, both with and without the involvement of pertinent line staff. Although rare and not considered extraordinary by the reviewer, preferential consideration has been given to a few board members who are also consumers of services. (In addition to board members understanding their conflict guidelines, given the practice of including consumers on the board, senior managers and line staff should also be made fully aware of what constitutes a conflict of interest for directors.) And the requirement that all cheques, regardless of the amount, must be "personally approved" by the Treasurer continues to this day. While the auditors might support the latter practice ("they love it"), it's still micro-managing the organization.

The view of an organization "totally controlled by its board" is also apparently held by other the CEOs of sister CCACs who are familiar with the operation and history of the HWCCAC: "The board tried to keep a tight rein on the CEO and the organization as a whole." It has been suggested by peers that "the COMSOC culture of micro-management" was a primary determinant in how the HWCCAC was governed from the start – "Hamilton never let go of that culture."

While the various incidents cited are random and neither a complete nor definitive summary, it does illustrate a pattern of behaviour that the board defines as its operational model of governance – which means regular and unabashed intrusion upon management responsibilities. The literature on governance resounds with criticism of so-called operational governance – boards that are "mired in administrative minutiae become less knowledgeable about the organization as a whole, less enthusiastic and less effective." (Chait & Taylor, 1989) The behaviour also raises the question of whether such a governance style requires a compliant CEO who is willing to do the board's bidding rather than face the negative consequences of challenging this paternalistic view of organizational stewardship. Boards always tend to fill management voids: "If management is weak in an aspect of its operation, a strong board or board member will move in and take over – often quite literally."

Recommendation #5:

In the spirit of recommendation #1, the board must re-examine those practices and protocols which see board members involved in essentially managerial functions. The board's focus must not be on "how" things are done but rather on "how well" they are done within its directions regarding organizational policies, strategic intent and desired outcomes.

Recommendation #6:

The CEO should not be an *ex officio* director but should attend board meetings primarily as a resource without voting privileges.

Recommendation #7:

The board should review its understanding of the ministry's conflict of interest guidelines to ensure all directors are fully aware and compliant with same. And, given the practice of including consumers on the board, senior managers and line staff should also be made fully aware of what constitutes a conflict of interest for directors.

The Chair

The role of the chair in governance requires special attention. He or she can be the single, most important person in ensuring that the board understands its responsibilities and "gets the job done" in an effective and efficacious manner. The critical attributes of an effective chair are leadership qualities, not functional or technical expertise. The chair must possess the ability to focus a team of talented volunteers on the organization's mission and its key responsibilities as the governing body, to ensure that all members of the board contribute fully, to demand continuous improvement of both management and the board, and to deliver fully on the expectations and accountabilities of those whom the board represents.

During the entire period under review, the same person occupied the chair. Not surprisingly, the character and style of governance have been heavily influenced by her since the inception of the organization. Strongly supported by at least two other founding directors, she set the tone for how the board and its committees would function. Perhaps demonstrating her undeniable commitment to the organization, its values and culture, she would occasionally intervene in the resolution of client concerns, sometimes without prior consultation with the CEO. She strongly influenced (and, it is alleged, in some cases determined) board and committee chair appointments as well as their terms of office.

Given the board's commitment to an operating style of "governance," none of the above is to be taken as a criticism but merely as observation. Her dedication to the well-being of the organization is not to be questioned; her understanding of the role of governance (despite being considered by some to be "an expert on governance") is, however, suspect.

The chair clearly has her supporters and detractors. Most directors regard her as a good chair. Among their positive evaluations are these:

- The board is fortunate to have her as chair – she is knowledgeable and credible.
- She encourages open discussion and participation.
- She is open, exceptional with the media and very democratic.
- ... very strong and experienced.

Those who disagree with this assessment of the chair offered the following views:

- She saw herself as an authority on how to run a CCAC ... so she ran it her way.
- I have never been on a board where decisions were made unilaterally by the chair ...

including the determination of the agenda and the terms of some board members.
- I wished we had time to discuss things other than what the chair wanted to discuss.

(Some who have been close to the administration of CCAC's since their inception suggest that the HWCCAC philosophy of governance was heavily influenced by the cultural orientation of the Ministry of Community and Social Services, where the chair was previously employed as a consultant by the closeness of her relationship with some ministry staff. This was described as a predisposition towards a "social services model of delivery" in contrast with a "health care model" which would be more consistent with the public policy thrust and service delivery requirements/ guidelines of the Ministry of Health. The reviewer notes the observation and distinction but has no prior knowledge of that culture nor how it may have impacted the nature of HWCCAC governance and its provision of services to consumers.)

Some non-management staff express their view of the chair rather succinctly, as follows: "The chair is the real CEO." Looking at the history of the organization and her pivotal role from the beginning, there is considerable evidence to support that contention. (Of note, the chair has retired and now serves as past-chair and, as such, is also a member of the Executive.)

Board Skill Sets

HWCCAC directors are of like mind in believing that the board and its standing committees have the right skill sets and expertise available to do the job at hand. The reviewer does not share that assessment.

Previous members of the senior management team disagree, however, offering comments such as:

- ... it is a very junior board with no proper orientation or appreciation of the scope of the job at hand.
- The current membership contains little in the way of business expertise or acumen.
- Instead of big picture planning and strategic responses, the board engages in discussing the viewpoints of individual clients.... You hear things like 'Mrs. Smith is unhappy ... her nurse keeps arriving 15 minutes late.'

These views are credible. The majority of the board members have limited experience in public sector governance and appear willing to accept most things at face value. It is suggested that an arena of healthy scepticism, challenge and urgency is not entrenched among the current directors. Indeed, in the reviewer's opinion, the directors demonstrate considerable naivete around some fundamental principles of governance. When presented with evidence of inappropriate behaviours, for example, most board members reacted casually with statements like "I didn't know that." or "I would be surprised if that happened." Directors also appeared to be lax their responsibilities concerning adequate financial and operational controls even though they were clearly knowledgeable about deficiencies in service delivery and inferior performance standards (see "Disconnects").

The membership of the board is skewed more toward health care specialists, academicians and community/consumer representatives than it is toward business and professional services. The former are more likely to put community need and quality of care issues before cash flow and fiscal responsibility. (This same distinction is evident on hospital boards where the focus and priorities of the medical staff are often noticeably different from elected directors whose expertise reflects private sector experience.) Indeed, some directors (relying on their own health care or social service experience) believe that "even more service is needed." It is an obvious deficiency in the skill sets of this board that a professional accountant has never served as a director despite the Treasurer's cavalier belief that "competency and credentialing are not always the same thing." In light of several findings from the operational review (such as the lack of adequate financial monitoring and reporting) that self-serving assessment ought to be reconsidered.

Acknowledging that (i) there is no such thing as a universally applicable template of skill sets that would work for all CCACs (given their unique challenges and histories), that (ii) board chemistry, teamwork and focus is as important as the procurement of specialized knowledge and required experience, and that (iii) community diversity and the changing needs of this evolving enterprise will influence board member recruitment, the following represents a suggested model of the type and balance of director expertise and community representation that CCAC boards (or their nominating committees) should endeavour to achieve:

- Financial background/credentials (at least two board members should possess private-sector financial expertise, one of whom being a credentialed accountant, in order to ensure continuity when terms expire);
- Legal (one is essential, but no more than two on a board of this size);
- Communications (marketing/public relations);
- Business leaders who work in environments where budgets are of a similar size to that of the organization (at least two are recommended, such as a company CEO or V.P. of Human Resources, Information Technology, Purchasing and/or Materials Management, etc.);
- Health care practitioner (such as a retired physician, nurse manager ...);
- Health care manager/business person (e.g., pharmacist, optometrist, dietician ...); and
- Community representatives (educator, police, housewife,....).

As a balance of skills and expertise is critical for ensuring healthy discussion, debate and challenge, there should not be a disproportionate representation of any one vocational, professional or other interest group (e.g., consumers, academicians, community representatives, etc.). Given the size of the board, it would be appropriate and advisable to establish maximum limits on the representation of such constituencies.

Given the suggestion of some interviewees that director selection and terms were influenced by the founding members, and the resistance of others to openly discuss this

issue, it is difficult to know whether this board has paid serious attention to succession planning and to the active recruitment of needed skill sets as well as in finding people who are willing to provide an arena of healthy scepticism and to occasionally challenge the board's *modus operandi* and its ability to change.

Recommendation #8:

In light of the findings of the parallel reviews, the governance of HWCCAC would be improved and strengthened were the board to be renewed. In so doing, due consideration should be given to three interrelated matters: (i) retaining up to four current directors to ensure adequate institutional memory; (ii) establishing a community-based mechanism, inclusive of acknowledged civic leaders and corporate members, to recruit new directors; and (iii) ensuring that the new directors are more representative of the skills, aptitude and inclination outlined in this section of the report.

Corporate Membership

After almost four years, HWCCAC has built a corporate membership of sixteen people, half of whom are voting members. (Non-voting members are typically suppliers, community partners or other parties with a potential or real vested interest). By contrast, the CCAC in Ottawa-Carleton is reputed to have 300 members, Halton CCAC has over 200 members, and Etobicoke CCAC has 130. No record is kept of the occupation of the eight voting (corporate) members but it is generally conceded that "almost all are retirees and current or previous consumers."

Corporate members are an integral part of the governance structure since the organization is accountable *to* the community *through* the corporation. Corporate members elect directors, approve auditors and board reports, and raise questions at the Annual General Meeting (AGM). A vital and active corporate membership offers numerous benefits, especially when nurtured through the infusion of regular, reliable and pertinent information regarding the organization and its activities, needs and challenges. An informed membership will not only render valuable counsel, it will serve as ambassadors and information disseminators across the community. Corporate members provide a rich talent pool for the board and its committees and they may be called upon, when needed, to help influence decision makers. It is also an opportunity to bolster accountability through a larger group that is more representative of the diversity and ethno-cultural mix of the community, something that is difficult to achieve with only 12 seats at the boardroom table.

This year's AGM of the corporation, held in January (10 months after the fiscal year end), attracted 17 people, including the directors. "Most of the attendees were either service providers or people from community support agencies such as Catholic Family Services." In contrast with the previous AGM, held on November 4/99, which attracted an audience of 111 people (and "was highly publicized with personalized invitations and a keynote speaker"), this event was not well advertised. The reasons were deliberate. Given media scrutiny and public interest, this would have been an excellent opportunity

to proactively "open the organization" to the community. Instead, "the board decided to take a much more low-key approach for this event, and only have a business meeting." This too is a reflection of the failure to develop a communications strategy (see "Stakeholder Communications").

One director advises that this board "didn't want to build an active corporate membership" for fear that it might "overthrow" the board – "we talked about this at the table." (This same "fear factor" was attributed to the penchant for closing business meeting to the public.) Another director cited the "fear of special interest groups ... like the Coalition for Long-Term Care" as a reason for not openly soliciting members. This concern is ill-founded as there are accepted and legitimate ways of guarding against the potential deleterious effects of special interest groups. From the staff perspective, there is little attention given to attracting corporate members. "We've never seen a membership drive" and "it's not actively promoted" are the perceptions given by staff when asked. Most directors appear apathetic: "I don't know ... no one ever raises the issue."

Curiously, there are some prime opportunities available to build interest in corporate membership. There were 40 applications for director in 1999. Assuming that three were chosen from this group, the remaining 37 might have been asked to express their interest and support for the organization (and position themselves well for a future application) by joining the corporation. Although (it is alleged because of the strike) there were fewer applicants in 2000 (12), this same opportunity presented itself again but without a request being made.

If the reason for not encouraging corporate membership is one of fear or loss of control, it is an indictment of the board's perception of its public accountability and its failure to see the strategic advantages that would accrue to the organization.

Recommendation #9:

The board should establish, as a top priority of the reconstituted Stakeholder Relations Committee, a strategy for building and nurturing a viable corporate membership and for encouraging its support and involvement in organizational matters, where and as appropriate.

Strategic Planning

A board is responsible for ensuring a strategic planning process is in place to guide the organization and ensure the effective stewardship of resources. There is presently no single, comprehensive document that describes the HWCCAC organization's strategic plan. (The common response from the directors is "we're working on that.") Instead, the component parts are to be found in several places – "some of (it) is in the board manual, some comes out of the planning retreat in February." In fact, there are several documents that, together, seem to comprise the strategic plan: a series of board policies referred to as "ends statements" (viz., E1, E2 and E3 dated March/97, October/99 and January/98 respectively), "strategic directions" arising from a board retreat held in February, 2000,

and the "draft" Service Plan for April/00-March/01. The latter item comes closes to delineating a detailed plan of action with measurable action steps.
In addition, although not specifically identified as part of the strategic plan (though clearly it must be), there is a "Final Discussion Paper" entitled *Service Delivery Model Redesign* (July 12/00) that appears to be the blueprint for the "system redesign" presently underway. (While senior management advises that the latter "change process, which started over a year ago, involved a lot of input from staff across the organization," the union leadership claim to be uninformed of the specific direction, action steps and desired outcomes of this process.) Surely, the organization's vision, mission and values, curiously defined as "ends statements," are integral components of the plan intended to guide its operational effectiveness and, ultimately, the efficient use of resources. It follows that it would be beneficial to the board, staff and key stakeholders if the above (and related, pertinent) materials could be consolidated into a single, coherent and comprehensive document that can be used to ensure the organization has both strategic focus and intent.

Recommendation #10:

In considering the findings of the operational and governance review, the board should review its strategic direction and priorities and assemble all relevant items into a comprehensive document that indicates clearly where the organization is going and what it needs to do in order to achieve those goals.

Stakeholder Communications

The TSE guidelines on governance responsibilities view stakeholder communications as a primary duty of the board. Indeed, by-law #1 (*re* Purpose) cites public information as one of four objects of HWCCAC. While the board chair claims that there is an external communications strategy in place, the fact is none exists. The only document that comes close to representing a coherent plan of action is a business solicitation/proposal made by a supplier to cover communications activities to the end of March, 2000. That was described by the CEO as "our communications plan." There is a freelance worker who provides communications support and beyond that, there is no identifiable strategic plan that would address media relations, internal communications or community and government relations. The organization does not have a stakeholder newsletter, there is no issues management nor tracking/measurement of accomplishments. The board does have a voice mail box (but staff are prohibited from accessing the calls received).

While it is unknown to what degree this failure to articulate a communications plan may exist among provincial CCAC's, the comparator CCAC deemed its communications strategy to be an integral component of public accountability. Its plan called for, *inter alia*, a four-page stakeholder newsletter distributed three times a year, the publishing of the annual report in community newspapers, informational brochures and posters as well as an active program for soliciting and offering community presentations, of which a call for corporate members was an integral component.

A strategic communications plan would not only guide efforts at informing stakeholders but also focus on methods for encouraging two-way dialogue. At present, there is either a disconnect or poor assumptions being made about how key stakeholders perceive the organization. The board generally believes it has an excellent reputation among its community partners and is of the opinion that they should have been consulted as part of this governance review. The staff appear to have a different impression of how the organization is currently viewed in the community: "We used to work collaboratively with our partners and suppliers, now it's dictatorial ... we tend to use the RFP process as a blunt instrument at times."

As further evidence of the lack of a definitive communications plan to guide the board, directors commented on the organization's failure to build relationships with the media and local politicians. The current focus of the standing committee on Public Relations, which is "to determine the continued need for this committee," only serves to reinforce the low priority assigned to this important board function.

The board also seems unappreciative of the importance of communicating internally. According to staff representatives, there are "huge communications gaps between the board and the rest of the organization." Frontline staff feel that the board undervalues their efforts: "At the AGM, the board and CEO go out of their way to thank the managers but not the frontline people." The board chair defines the relationship with the union as "open and collaborative;" the union characterizes the relationship as "toxic." (See also *Relationship with the union* under "Disconnects.")

The directors acknowledge that, with all the other issues before it (labour unrest and staff morale, adjusting to the fiscal deficit, system redesign, the current review, etc.), communications is a low priority. They fail to see the relationship between an investment in communications (e.g., as described under "Corporate Membership" above) and these equally important issues.

Somewhat indicative of the lower priority given to external communications, the HWCCAC website (http://www.hwccac.on.ca) has rarely been updated (if at all) since its construction over two years ago. For example, there are two items listed under "News" and both are dated November/99. The site is also linked to a dozen or so sister CCACs in the region and a cursory "surf' of those sites indicates greater attention to the Internet as a convenient vehicle for disseminating information to stakeholders. Some sites contained information that had been placed within the same week as this survey was done.

There are simple solutions to this problem but they begin with an understanding of the value of stakeholder communications and a commitment to ensure an appropriate investment in ensuring a plan of action is developed and implemented by management.

Recommendation #11:

The board should direct its Stakeholder Relations Committee to develop a comprehensive stakeholder communications plan of action in a timely manner and provide adequate

resources to enhance the corporate image and improve relations with internal stakeholders.

Board Orientation

On the surface, the board appears to have taken director orientation seriously and has developed appropriate materials and opportunities to ensure that new directors understand "the business" and (in theory at least) their role and responsibilities. That being said, this knowledge does not appear to have been operationalized (*per* observations made under "Accountability").

While the orientation program (as described) seems well designed, not all board members appear to complete it in a timely fashion ("my orientation program came six months after I started."). Another director indicated that his orientation to the board consisted of "receiving a package of policy manuals – that's it."

Two directors indicated that they had been assigned a mentor (in both cases cited, it was the same individual – also a founding board member). While the practice is laudable, it is unclear as to whether it constitutes standard operating procedure.

Today, more than ever, volunteer boards need training programs that enable them to understand how to function as a board during difficult times. Since "learning how to be a board member can be intimidating," consideration should be given to further enhancing the existing orientation program by equipping new board members with a knowledge of the governance model previously described (rather than relying on the intent of longer serving directors who have a hard time "letting go" of the more intrusive operational style).

While the design of the February 2000 board retreat is an excellent model for other CCACs to emulate, future board retreats might consider the merits of discussing such pertinent topics and issues (using case methodology) as the following:

- how to lead an organization in a unionized environment and the critical importance of leveraging intellectual capital;
- brokerage, partnership and relationship management;
- the relationship between the core competencies of the enterprise: information and resource management, contract administration, coordination of health care services and the need for community collaboration;
- the value, discipline and relevance of strategic thinking and planning.

Recommendation #12:

In considering the findings of the operational and governance review, the board should review its current orientation program, materials and objectives and then revise or enhance same as needed.

What things are done right?

The board does encourage and involve community representation on its standing committees whenever appropriate skill sets are needed but missing in board membership. This practice should be continued and expanded so as to provide a needed talent pool of expertise that has not traditionally been represented on the board (e.g., chartered accountants). It is admirable also that the focus of committee work appears to be based on outcomes from a board retreat (the last one occurring in February 2000). The extent of staff participation on these committees was not examined.

Effective board decision making places a premium on good information management. Many boards simply do not receive the kind of information they need to do the job, nor in a sufficiently intelligible form to make the right decisions. For example, Orlikoff claims that "fully 75 percent of the information contained in most board agenda materials is irrelevant to the critical, strategic issues confronting the organization." The board is satisfied that the information it receives from management is pertinent, timely and in a format that addresses the board's needs. So information management seems not to be an issue. [The findings of the operational review will determine whether the information provided by management is sufficient for the board to understand and act upon the critical issues.]

"Disconnects"

The comments of some directors seemed to suggest that they were either out of touch with their colleagues or trying to frame a difficult issue in the most favourable light. Rather than judge the veracity of such statements, they are presented below as "disconnects."

1. ***Accuracy of minutes***
   Virtually all of the directors indicated that board and committee minutes were "an accurate reflection of what goes on." When presented with evidence to the contrary, they were at a loss to explain the discrepancy between perception and fact. In one especially egregious example, while an important item of business appeared on a meeting agenda and was discussed at length, the minutes of said meeting make no mention of this deliberation. When confronted by the omission, several directors present at the time could give no explanation; only the chair responded by saying that "the item was never received" (albeit it was clearly discussed). It is doubtful that the non-recording of contentious items in the official minutes of the board was limited to this isolated incidence. Indeed, one of the founding directors indicated that "the early minutes did not reflect what happened in our board meetings." And more than one director believed that "comments made were not reflected in the minutes."

2. ***Relationship with the union***
   The union represents HWCCAC's non-management staff. While most directors say that the board does not have a relationship with the union ("we don't have anything to do with the union – the CEO looks after that"), curiously they do see culture building

as a board responsibility. As previously noted, there is a disconnect in how each party perceives the relationship. The board assessment of a relationship that is "collaborative and open" is not shared by the union leadership. Indeed, the following comment might fairly sum up the board's view of its challenge with the workforce: "We have an angry core who are not open to change."

One director indicated that "the CEO gives us reports on this ... but we don't act on them." One such report, based on a staff survey conducted in the early summer of 2000, included the finding that "Management is described as 'inflexible, controlling and dictatorial' and there is a concern that individual managers do not have the skills to steer us through the upcoming change process." Although the CEO noted that this finding was "consistent with my own analysis of our management strengths and weaknesses," the directors who were questioned about follow-up activities indicated no action had been taken.

The hard feelings generated by the strike are slow to dissipate on both sides of the table. One director was still concerned that "during the strike, the union was not honest." The director described as possessing expertise in union matters declined that assessment of his experience or contribution. [The reviewer has learned of a current initiative to bring in a facilitator who is familiar with labour relations in order to help repair this relationship. That initiative, if well designed, is to be applauded.]

3. ***Stakeholder communications***
The widest discrepancy in director responses involves the degree to which they see the organization seriously involved in reaching out to the community and key stakeholders. Responses range from "we are very public in the community" to "this is not our role" and "we don't do this very well." Some directors say that there is an external communications strategy in place; others say there is not "but we're working on that." All are agreed that little if anything has been done to build the corporate membership – "with all that is going on, this is not a priority." (Refer "Corporate Membership" above.) Some view stakeholder communications very passively – "we have pamphlets that go out." The same attitude seems to apply to the corporation – "memberships are available." Directors could not understand the external perception held by some of being a closed board while simultaneously wondering "how valuable are open meetings – it's really not that big a deal." Perhaps again reflecting the board's skill sets, the directors' appear to be either naive or unsophisticated in their knowledge of the value and role of stakeholder communications.

4. ***Knowledge of operational challenges and internal controls***
Two of several questions asked to pinpoint the board's knowledge of operational concerns and methods of responding to them suggest a disconnect from the realities of and the responsibility for organizational performance (although all would blame the current information system – CASIS – for this lack of knowledge).

All directors believe that clients receive the services ordered for them (by case managers). The qualifications added to that assessment were:

- Yes, but some may have to wait a bit.
- Maybe 5% don't.
- 1-2% don't but these are eventually caught.
- ... services can be delayed for up to 10-14 days sometimes.

The CEO believes the figure to be "closer to 10%." When another director, who responded "yes" was presented with the "closer to 10%" scenario, said he "would not be happy if it was as high as 10%." The operational audit, in a random check, indicates that figure to likely be much higher.

All directors (save one) know that service utilization is not being monitored as it should, that assessment and determination of eligibility is weak and that there are infrequent reassessment visits. (Other than the chair, who believes that service utilization is being monitored as it should, the common response was "not at all surprised.") All directors advise that the service redesign is intended to address these deficiencies.

Directors were asked (on a scale of 1 - 10, with 10 indicating full confidence) to indicate their confidence level that HWCCAC presently has in place the necessary financial and service utilization controls to effectively manage risks to the organization (the *raison d'etre* of trusteeship). The responses given varied from 6 to 10 (more specifically, the numbers given were 6, 6.5, 6.5, 7, 7, 7, 7, 7.5, 9.5, 9.5, 10 and 10 (of these scores, the Treasurer indicated 10 on financial controls and 6.5 on service utilization). Given the board's knowledge that its controls are somewhat suspect (average score of 7.7), it is appropriate to ask why greater attention and urgency have not been given to this concern?

5. ***Influence of the executive and chair***

The chair advised the reviewer that, in her judgement, the Executive had "very little" involvement in day-to-day management of the organization. Others concurred with that view. While degree is a matter of perception, the evidence is clear that intrusive, hands-on "governance" was the accepted *modus operandi* (and not inconsistent with the directors' own views of operational governance described at the outset).

Disparate director comments indicate this disconnect to be palpable (with the extremes perhaps best characterized by these responses):

- We don't meet very often – other than our involvement with the strike, we really have a small role to play. (*Note*: The executive met formally *in camera* or via teleconference seven times over a two month period between October 5 and December 7/00).
- The organization has been managed and maneuvered (by the executive and chair) for quite some time.
- Some representations to the ministry were not decisions that had been made by the board.
- They are far too hands-on in dealing with personnel matters.

- The executive had way too much power ... they don't meet often but they are talking to one another on the phone all the time.

The same disconnect regarding the role of the executive and chair seemingly applies in the recruitment and selection of senior staff and new board members:

- We are completely hands-off when it comes to recruitment....
- Everyone gets hand-picked....
- ... wouldn't allow me to be on certain committees, even though I asked several times.
- We made up our mind to get rid of ____ but we didn't want to order it or appear to meddle so we put (him) in a position where (he) had no choice but to resign.

Among directors who are involved with the identification and recruitment of new board members, there is disagreement as to whether the approach to new director selection is active or passive. While the board's own protocol requires "at least two interviews conducted by the Nominating Committee," at times, single interviews were conducted by the chair on her own. More than one director indicated that their perception was the chair had decided on their appointment to the board. When asked about the appointment of a specific director to the board, the chair advised that she had not approached the candidate directly. The director in question held a contrary view: "she called me and asked if I was interested in serving and then she interviewed me (on her own)."

Given the variety and differences of opinion on the issues (or "disconnects") identified above, it's virtually impossible to say where the truth might lie. Members of the executive even disagree among themselves as to positions taken on staff/board recruitment and retention issues. Self-professed "excellent" memories suddenly become cloudy when asked to verify statements made. Answers given in interviews are subsequently clarified several hours later, presumably following discussion with a colleague. Directors admitted to "circling the wagons" and professed to being "a combative board." In some cases, the reviewer could discern this veil of loyalty but was unable to penetrate it. Given these circumstances, it is advisable to simply identify the conflicting viewpoints without judgement. While this board has an overriding concern that "shadowy hearsay and innuendo be put to rest," in many ways, when it comes to providing clear, unambiguous and straightforward answers, it is the author of its own misfortune.

Appropriate recommendations to address the above issues are made elsewhere in this report.

The Current Governance Model

In the reviewer's judgement, the current model – *viz.*, a community-based board, should be maintained. The HWCCAC board's default on its fiscal responsibility to taxpayers and, in effect, its mandate under the ***Long Term Care Act***, on the misguided understanding that "maintaining services" was a licence to function with poor service delivery controls and/or a deficit, should not be viewed as an indictment of the model.

Without further investigation of other CCACs, the behavioural pattern of governance within the HWCCAC might simply be an aberration. Its roots go back to the founding members and their unique view or interpretation of how the organization should be run and be built over time.

A community board offers the promise of local leadership, local accessibility and accountability, and local knowledge of needs and resources. Properly constituted and focused, with the right skill sets as outlined, and fully aware of the purpose and responsibilities of governance, a community board can add value and needed stewardship to the delivery of extended and long-term health care services. Alternate models of governance (such as using a hospital or DHC board or returning organizational leadership and direction to the ministry), on analysis, are fraught with greater downsides and unknowns than is the current arrangement for providing strategic direction and leadership to the province's CCACs.

That being said, the evolution of this board, the ongoing changes in management, the influence of certain directors and the challenges it has had to confront in "learning how to be a board" are likely not unique in the context of province-wide CCAC governance. While many progressive boards will doubtless find the issues examined and the benchmarks and best practices outlined in this report to be instructive, there would be a value in creating a "template" on key governance principles for others to compare and evaluate their own structures, processes and experiences.

Recommendation #13:

The ministry should consider the merits of adapting the recommendations for enhancing governance at HWCCAC, as appropriate, to the needs and challenges faced by other CCACs in the province.

Outcomes

All interviewees were asked what they wanted to see as the outcomes from the governance review. As will be noted, with few exceptions, there is a strong sense that the review should validate the board's performance:

- Objective recommendations to strengthen the board.
- Recognition that the board has taken its responsibilities seriously.
- Put the shadowy hearsay and innuendo to rest ... for example, that we're a closed board.
- Identify the strengths of the board.
- That we are a dedicated group that managed a difficult situation.
- How do we interact with the ministry?
- Validation that we were on the right track.
- Identify areas in need of improvement and change.
- Let them know where we've done a decent job.
- Identify our strengths and tell us where we should go next – give us positive strategies for continued growth.
- Find ways where we can improve.

- Indicate that we are on the right track and open in how we do things.
- An honest report. We're an excellent board and (the report) should reflect that.
- A clearer idea of the ministry's expectations and recommendations for better governance.

In seeking to appraise this strong need for validation, particularly in light of the board performance and its understanding of governance, the following director's comment offers sober perspective: "the board doesn't want to accept responsibility for what went wrong."

Regarding director recommendations for improving governance, the following questions were also asked: In general, what needs to be done to make this a better board? Do you think you have the right governance structure to meet the needs of the organization into the future? How might it be improved?

- We're O.K. the way we are ... I'm proud of what we've done.
- We need to be more diverse and, if this is any indication, we need training in governance.
- We have the right structure – just let us take it to the next level. Let the dust settle.
- We need more information from the ministry to do long-term planning.
- We need to be more proactive in looking at the big picture issues.
- More frequent evaluation.
- We need to be more knowledgeable about governance.
- Establish our political connections.
- Improved communications with the ministry. Better evaluation of consumer needs and their satisfaction levels. New models for service delivery – how to make services go farther.
- I'm satisfied with the way things are. We just need more funding.

The above expectations and concerns have been addressed in this report.

In Closing

The fundamental purpose of this report is to assist the client in better understanding the nature of governance at the Hamilton-Wentworth Community Care Access Centre, to outline the reasons why it was unable to effectively lead the organization through a period of fiscal turbulence, and to make recommendations for enhancing this vital stewardship role.

What emerges as a top-line conclusion is that the HWCCAC Board, from the beginning, has focused its efforts more on exercising command and control over the organization than in providing it with strategic direction and leadership. Rather than empower and counsel senior management, it has chosen to continue an entrenched style described as "operational governance." This approach to organizational stewardship has been manifested over time in many ways – in the recruitment of compliant chief executives, in the failure to ensure a transparent operation and in behaviours that suggest ownership rather than sound governance.

The board as investigated (see Appendix A) is generally naive about its public accountability, arrogant in its ***modus operandi***, largely oblivious to the need for proactive communications with its primary stakeholders, and lax in not acting more quickly on a worsening fiscal crisis when it confesses to have known about its own service delivery deficiencies. As is recommended in this report, the governance of this important organization to the consumers of health care in the region can only be improved and strengthened in an expeditious manner through outright board renewal.

Our findings, observations and recommendations are intended to rectify current deficiencies, reflect best practices and create a firm foundation for strong governance and vibrant organizational leadership. Collectively, the recommendations contained in this report provide a framework for enhancing the board's function, its accountability and the future stewardship of HWCCAC to the benefit of its principle stakeholders – employees, consumers, corporate members, the community of Greater Hamilton, local and provincial governments, health care groups and other partners.

APPENDIX A - BOARD MEMBERS INTERVIEWED

Mary Burnett (*ex officio*)

Tish Butson

Paul Donoghue* (Treasurer)

Aznive Mallett (resigned Dec./00)

Brian Mullan

Gary Ostofi* (retired Jan./01)

James Peters (current Chair, joined Board Sept./97)

Joan Royal

Terry Shields* (current Past Chair)

Joe Spatazzo

Fran Willey

John Wilkins* (retired Jan./01)

Refused to be interviewed:

Anju Joshi* (retired Jan./01)

* *Indicates founding Director*

APPENDIX B - RELEVANT LITERATURE ON GOVERNANCE

Those wishing pertinent background materials on the subject of governance reform and effectiveness would find the following publications especially helpful:

Arrington, B. "Continually Improving Governance." *Hospital and Health Service Administration* 40:1, 1995

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Scharf, M., Dick, M. and J. Barnslev. "Board Evaluation and Effectiveness: Models, Components and Perspectives." *Leadership* 3(1): pp. 34-37, 1994.

Sinclair, Duncan. *Hospital Restructuring: The Changing Face of the Hospital Sector.* 1996.

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St. Joseph's Health Care System. *Roles and Responsibilities of the Board of Directors and the Board of Trustees*. December 1996.

Taylor, Barbara, Richard Chait & Thomas Holland. "The New Work of the Nonprofit Board, *Harvard Business Review*, September-October 1996, pp. 36-46.

Toronto Stock Exchange Committee on Corporate Governance. *Where Were the Directors? Guidelines for Improved Corporate Governance in Canada*, Toronto, December 1994.

Toronto Stock Exchange and Institute of Corporate Directors. *Report on Corporate Governance, 1999: Five Years to the Dey*, Toronto, 2000.

Verlan, Liz. Integrated Health Systems: A Common Sense Approach to Reinventing Human Services in Ontario. Quantum Solutions, 1995.